Information update: New Patient

Date:_____
Patient Name: _____ Birth Date: _____

REFRACTION FEE

One of the most important parts of your eye exam today is the refraction. That is the part of the eye exam by which we determine your best visual acuity and whether you can be helped by new glasses. It is **NOT** a covered service by Medicare and some plans. Our office fee for refraction is **$45.00**, and unless your plan covers the refraction charge, this fee is collected at the time of service **in addition to any co-payment your plan may require.** If you choose not to do the refraction, we will not be able to do a comprehensive exam.

I have read and understand the above refraction policy. X_____

Signature of Patient or Representative Date

CONTACT LENS FITTING FEES

Contact lens fitting is charged separately from your eye exam. The fitting fee includes determination of the lens type, curvature and power. Also included are trial contacts as required and visits related to the contact lens fitting for 3 months. The fitting fee varies greatly depending on the type of contact lens and the complexity of the fit. A fitting fee is charged even if there is no change to your contact lens prescription.

The contact lenses are charged separately and our prices are competitive with national suppliers. Contact lenses are not covered by your health insurance.

I have read and understand the above contact lens policy. X_____

Signature of Patient or Representative Date

CANCELLATION AND NO SHOW POLICY

We understand that situations arise in which you must cancel your appointment. It is therefore requested that if you must cancel your appointment you provide more than 24 hours notice. This will enable for another person who is waiting for an appointment to be scheduled in that appointment slot. **Office appointments rescheduled or cancelled with less than 24 hours notification are subject to a $40.00 fee.** Patients who do not show up for their appointment will be considered as **NO SHOW** and subject to a **$40.00** fee. These fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment.

I have read and understand the above Cancellation/No Show PolicyX_____

Signature of Patient or Representative Date