C&R Vision Center

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Please Initial:

_________ Routine Appointments with Medical Findings: You are responsible for the MEDICAL copay, in addition to the Routine copay which may be different.

_________ Contact Lens Wearer: A Contact Lens Evaluation Fee is due yearly at your routine appointment. Charges may vary depending on lens type.

_________ Deductible Insurance Plans: Charges are due the day of the appointment for all Routine exams. A billing charge may apply if not collected on the date of service.

Notice of Privacy Practices

Please Initial:

_________ I authorize the release of any Protected Health information (PHI) necessary to process the claim. I also authorize direct payment of medical benefits to my doctor.

_________ I understand that verification of coverage is not a guarantee of payment. Actual payment will be made when a claim is received, and I will be responsible for any balance my insurance company does not cover.

_________ I have been given the opportunity to read/or receive a copy of this office Notice Of Privacy Practices.

_________ I authorize to release my records/information to the following people:

____

Patient Name(print):___________________________________Date of Birth:________________

Signature/Guardian:___________________________________Date: ______________________

Relationship to Patient:_________________________________