PRIVACY NOTICE

I acknowledge have received a copy of Gainesville Eye Physicians Privacy Standards Notice of Health Information Practice.

PATIENT FINANCIAL POLICY

Co-pays, Co-insurances, deductibles and non-covered services are due at time of service. A **$10** charge will be added to any balance if not paid at the time of service.

CANCELLATION POLICY

A 24 -hour notice is required for appointment cancellations. A **$40** fee may be charged to the account if not cancelled within this time frame or if you do not show for your appointment.

REFRACTION POLICY

A Refraction is **NON-COVERED** service and is not paid by your insurance company. There is a **$40 charge due at time of service.**

ASSIGNMENT OF BENEFITS

I hereby authorize the release of my medical or other information Necessary to process this or any other related insurance claim.

I hereby authorize the release of information to other physicians or laboratories rendering services.

I have been advised that there is a possibility that some services may be denied as "Not Medically Necessary" or non-covered services. I acknowledge and accept liability for full payment for the present and future services, regardless of my insurance carrier's payment.

_____ _____

SIGNATURE (GUARDIAN-IF MINOR) DATE

_____ _____

PRINTED NAME IF MINOR (RELATIONSHIP)