AUTHORIZATION TO PAY INSURANCE BENEFITS TO CLINIC I hereby assign payment directly to Envision Eyecare for medical and vision benefits, otherwise payable to me, for service provided at the clinic. I understand that Envision Eyecare estimates what the insurance will cover, but I am financially responsible for all charges not covered by my insurance. If I do not provide the most accurate and current insurance information and identification, I will be liable for services rendered.

OFFICE POLICIES Prescription eyewear, because they are a custom-made product, cannot be canceled after 24 hours of order placement. All frames have a workmanship defect warranty for 1 year (cannot be glued). Lenses with a premium antireflective coating have a 1-time scratch warranty for one year from the date of purchase. Our policy allows for one exchange to a different lens, frame, or prescription, of equal or lesser value, within 30 days of original order for a $40 fee. Patient can pay difference if upgrade is needed. No refund applies if cost is lesser. There are no warranties when a patient's own frame is used. There is an adjustment/repair charge for glasses purchased elsewhere. Boxes of contact lenses may be exchanged if they are unopened, unmarked, and are at least 1 year from expiration. Please let us know if we can help with any concerns you have with glasses or contact lenses. A fee for appointments canceled with less than 24 hours' notice will apply.

AUTHORIZATION TO RELEASE INFORMATION I hereby authorize Envision Eyecare to release any information acquired during my examination to another physician and/or my insurance company. I consent to receive requested records and information via text or email. We will attempt to send email encrypted, if possible. I understand there is a higher confidentiality risk with email and texts.
In addition to myself, I designate the following person(s) to access my medical and financial records:

Name _____Relationship_____Phone_____

ACKNOWLEDGEMENT I have read and understand the above financial and office policies, and benefit authorization and agree to all provisions outlined herein. I understand that I can receive a copy of the Notice of Privacy Practices at the time of my exam if I request it. I understand that I may request restriction on the use and disclosure of my protected health information.

Patient's or Legal Guardian's First and Last Name _____

Signature_____Date_____