STATEMENT OF FINANCIAL RESPONSIBILITY

1. PRIVATE INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS & RELEASE OF INFORMATION

I hereby authorize and direct payment of my benefits to Herkert Family Eye Care, P.C., for any services furnished to me by the Optometrist. I authorize Herkert Family Eye Care, P.C., to release any information, including diagnosis and the records of any treatment and examination rendered to me during the time period of such medical services to third party payers and/or health practitioners. In the event that my health plan determines a service "not covered", I will be responsible for the complete charge. I agree to be responsible for payment of all unpaid services rendered on my behalf or my dependents, including any collection services noted.

2. AUTHORIZATION OF PAYMENTS

I understand that as a courtesy, Herkert Family Eye Care, P.C. may assist me in verifying my benefits and submitting my claim(s) to my insurance carrier. I hereby authorize payment directly to Herkert Family Eye Care, P.C. of benefits, otherwise payable to me for services provided. I understand that I am financially responsible for any insurance co-pay, co-insurances, deductibles, and non-covered services.

3. MEDICARE LIFETIME SIGNATURE ON FILE

I request that payment of authorized Medicare benefits be made to me or on my behalf to Herkert Family Eye Care, P.C. for any services furnished to me by the provider of service. I authorize any holder of medical information about me to release to the Center for Medicare Services and its agents any information needed to determine these benefits or the benefits payable for related services.

4. MEDIGAP AUTHORIZATION FOR ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION

I request that payment of authorized Medigap benefits be made either to me or on my behalf to Herkert Family Eye Care, P.C. for any services furnished to me by the provider of service. I authorize any holder of medical information about me, to release any information needed to determine these benefits payable for related services to the Medigap insurer and its agents.

5. CONSENT OF TREATMENT

I hereby authorize Herkert Family Eye Care, P.C., through its appropriate personnel, to perform or have performed upon me, or the patient I am responsible for, appropriate assessment, tests and/or treatment.

6. INSURANCE DISCLAIMER

You are responsible to notify Herkert Family Eye Care, P.C. of your current insurance information and to provide the necessary information about your insurance plan; therefore, it is your responsibility to have a current insurance card, as well as a photo ID such as a driver's license, military ID or government issued ID.

7. HIPPA PRIVACY POLICY

My signature below is acknowledgement that I have received the Notice of Herkert Family Eye Care's Privacy Practices.

8. CANCELLATION POLICY

We require a 24-hour notice for cancellation of any appointments scheduled. A fee may be assessed for noncompliance or for missing a scheduled appointment during these hours.

9. CONTACT LENS AGREEMENT

Contact Lenses are medical devices which require ongoing medical care for optimal performance and safety. Contact lens services are not included with the exam copay. Insurance may not cover Contact Lens Fitting Fees/Services in full. The Contact Lens Fitting/Evaluation Fee covers up to eight (8) weeks of follow up care for contact lens related matters. It is the responsibility of the patient to return for all contact lens appointments during this period to release the contact lens prescription. It is also the responsibility of the patient to contact Herkert Family Eye Care if any signs of complications occur including pain, redness, or loss of vision. If a different contact lens is required during the eight (8) weeks of follow up care, the patient will be notified of any additional charges before the service is rendered.

PROFESSIONAL SERVICES ARE NON-REFUNDABLE.

10. CONTACT LENS PURCHASES

All sales of Prescription Contact Lenses are Final. If, however, there are discrepancies between the Doctor's Prescription and the lenses ordered/received, contacts may be exchanged, **unopened** within 90 days and may be subject to a restocking fee.

Patient Name (Please Print)	
Signature of Patient (or Responsible Party)	Date

OFFICE POLICY FOR EYEGLASSES

ALL SALES OF PRESCRIPTION AND NON-PRESCRIPTION EYEGLASSES AND SUNGLASSES ARE FINAL

- All orders require a minimum 50% deposit.
- If, however, there are any discrepancies between the Doctor's prescription and the lenses manufactured by the lab, or between the Doctor's prescription and the actual prescription, any adjustments to the prescription lenses are included at no charge within 60 days from the original date of service.
- Lens wearers who are unable to adapt will be given the option for a **1 TIME** remake with alternate lenses. Any additional upgrade to frame or lens ordered after the original purchase date, the patient will be responsible for the fee. **UPGRADE FEES ARE NON-REFUNDABLE.**
- If a patient requests a special order (out of stock) frame to view, no charge will be incurred on the first date of service. For any additional frames requested, there will be a shipping fee applied. The shipping fee will be applied to the order if the patient chooses to purchase. If the patient decides not to purchase the frame or frames, the shipping fee will **NOT** be refunded. Frames will be held for **30 days** from date of service.
- Prescription orders must be canceled within 1 business day of ordering. A fee may be applied for cancellations after 1 business day if orders have processed already.
- PROFESSIONAL SERVICES ARE NON-REFUNDABLE.

REPAIRS AND MAINTENANCE

- We will service repairs to glasses under warranty at no charge provided the eye-wear was purchased at Herkert Family Eye Care. Any repairs that require additional parts, special orders, or must be sent to the lab will be charged accordingly.
- Glasses purchased outside our office will be serviced and charged accordingly. We recommend frames purchased at another location be serviced through that provider as HERKERT FAMILY EYE CARE IS NOT RESPONSIBLE FOR REPLACEMENT should breakage occur.

PATIENT'S OWN FRAME

• We are happy to make new lenses for a previously purchased frame. We pledge to take the utmost care in handling it. However, there is a small possibility that the frame may be damaged or lost during the fabrication process. The lab and Herkert Family Eye Care will NOT be responsible for replacement or reimbursement if that should occur. If the frame breaks during the new lens insertion process, the lenses made for that frame cannot be placed into a different style frame. We will make new lenses at no charge for a new frame, but the cost of the replacement frame is the patient's responsibility.

WARRANTY ON FRAME & LENSES

- All eyeglass frames come with a manufacturer warranty for any manufacturing defects for up to 1 year from date of purchase. This <u>DOES NOT</u> include lost or stolen eye-wear or animal damage. All parts and pieces must be returned with damaged frame to qualify for warranty replacement.
- Herkert Family Eye Care does offer an additional 1-year frame warranty for \$25 at the original date of purchase.
- Even though the eyeglass frame is under warranty by the manufacturer, the manufacturer <u>DOES NOT</u> pay for the shipping and handling for the exchange of the defective frames for the new frames. The patient will be responsible for the two-way shipping costs involved, which is approximately \$15. Keep in mind that, as a courtesy to our patients, we do (1) Exchange the frames; (2) order the proper lenses for those frames; (3) cover lab cost as necessary; and (4) physically remount the lenses into the new frames at NO ADDITIONAL FEE.

POLICY FOR PICKING UP EYEGLASSES

All eyeglasses that have been prescribed, fitted, and purchased by the patient will be kept in the office for a total of **90 days**. If the product remains in the office after 90 days:

- Herkert Family Eye Care will mail the product to the address on file if paid in full.
- If a 50% deposit was made, the patient will be charged for the lens cost and restocking fee for the frame. Any balance left over from those charges will be credited to the patient's account for a future purchase.

Patient Name (Please Print)		
Signature of Patient (or Responsible Party)	Date	