20/20 Vision Care

Quality Eye Care You Can Count On!

Dr. Jaime Hall-Malouf
Therapeutic Optometrist

PAYMENT, RETURN & COLLECTIONS POLICY

It is our office's policy that no merchandise leaves our office without first being paid for in full. This includes frames, lenses, contact lenses, supplements, accessories, and medications. All exam co-pays are to be paid in full at the time of your visit, without exception. If these are not paid for in full and merchandise is dispensed, please be advised that you will be billed for the balance due on your account. If this balance is not settled in a timely manner, you will be sent to collections. If you cannot pay for you rmerchandise in full, we do accept half-down as an acceptable arrangement. Half of your total charges for the glasses/contact lenses AND your exam fees will be accepted and he other half will be taken at the time you pick up your merchandise.

It is our policy that no refunds are processed for returns due to buyer's remorse, so please be sure that you are satisfied with your selections of both frame and lenses before you finalize your purchase. You will not be able to return them should you decide you do not like them. Please also be aware of the fact that we are happy to make any changes needed in regards to your prescription, but due to the nature of our relationship with our manufacturer, we cannot return nor refund them. We have a non-adapt policy that extends the full year of the prescription. If you cannot adapt to the particular lense you selected (i.e. You wanted to try a noline bifocal but could not adjust to the design), we will replace your lenses in a more suitable design. There is no refund for a non-adapt, and there is no cost for the replacement.

You agree, in order for us to service our account or to collection any amounts you may owe, we may contact you by telephone number, which could result in charges to you. We may also contact you by sending text messages or e-mails, using any e-mail address you provide to us. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable. I have read this disclosure and agree that the Creditor may contact me as described above.

FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS

In consideration for receiving medical or health care services, I hereby assign my right, title and interest in all insurance, Medicare/Medicaid, or other third party payer benefits for medical or health care services payable to me, payable to 20/20 Vision Care. I certify that the information I have provided in connection with any application for payment by third party payers is correct. I agree to pay all charges for medical and health care services not covered by or which exceed the estimated amoungt to be paid or actually paid by my insurance company and agree to make payments as requested by 20/20 Vision Care.

ATTN: PLEASE BE ADVISED IT IS YOUR FINAL RESPONSIBILITY TO MAKE SURE YOU ARE USING A PARTICIPATING PROVIDER OF YOUR INSURANCE, IF YOUR INSURANCE DOES NOT PAY, YOU ARE RESPONSIBLY!

CONSENT TO TREAT AND PRIVACY POLICY

I voluntarily consent to receive medical and health care services provided by 20/20 Vision Care, employees and such associates, assistants, and other health care providers as my physicians deem necessary. I understand that such services may include diagnostic procedures, examinations, and treatment. I acknowledge that no warrany or guarantee has been made to me as to result care. I understand that this consent to treatment will be valid and remain in effect as long as I am a patient of Dr. Jaime Malouf unless revoked by me in writing.

I have received and read the HIPAA policy and understand that this act protects the privacy of all y medical records.

PAYMENT DUE WHEN SERVICES ARE RENDERED, PROFESSIONAL FEES ARE NON-REFUNDABLE, GLASSES EXAM FEES DO NOT INCLUDE A CONTACT LENS PRESCRIPTION

_____ _____

Signature **Date**

_____ _____

Witness **Date**