PRIVACY POLICY & FINANCIAL DISCLAIMERS

Name: _____

This notice applies to the following family members:

Privacy Policy

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for services, and to conduct healthcare operations involving out office. The Privacy Policy describes these uses and disclosures in detail.

I acknowledge that I have been offered and/or received a copy of the Privacy Policy from **Walnut Creek Optometry Group (WCOG) or Vallejo Optometry Group (VOG).**

Date: _____ Signature: _____

Financial Disclaimer

Eligibility for Medical Insurance and/or routine vision benefits:

We will attempt to verify your plan eligibility for services and/or materials before your appointment. ***Verification of eligibility is done as a courtesy only; it is not a guarantee of payment.*** Please check with your plan administrator if you have any questions regarding your eligibility. We **DO NOT** participate in any HMO plans.

Liability

If I have medical insurance or routine vision benefits, I authorize my plan carrier to directly pay Walnut Creek Optometry Group or Vallejo Optometry Group. I also authorize WCOG or VOG to release any information required for payment to be made. ***If my plan carrier does not pay, or partially pays, I understand I am responsible for payment in full or the remaining balance.***

My signature below verifies that I understand this agreement and the above financial disclaimers.

Date: _____ Signature of patient over 18 or parent of patient: _____

Contact Lens Fees

Contact lens evaluation services are not an included part of an eye health exam and vision assessment, and additional fees apply. Fees are customized according to the complexity of the case and the predicted time necessary to care for the individual patient.

Fees for contact lens evaluation services range between $80 and $300 (please ask the staff to estimate your fee). Extra fee of $35 charge for follow up after 60 days from initial refit date. As with glasses, contact lens materials are an additional fee.

My signature below verifies I understand the contact lens fees.

Date: _____ Signature: _____

Refraction Fee

The part of your evaluation that determines your prescription is called a refraction. A refraction is also done under certain circumstances for diagnostic purposes. ***If you have routine vision benefits such as VSP, EyeMed, or Medical Eye Services, your refraction is typically included with your exam benefits. Medical insurances that do not include rout vision benefits, such as Medicare, DO NOT cover refraction. The fee for Refraction is $50.***

My signature below verifies I understand the Refraction fee.

Date: _____ Signature: _____

VALLEJO OPTOMETRY GROUP
WALNUT CREEK OPTOMETRY GROUP

***Cancellation Policy*:** There's no charge for cancellation that occurs in the same day before 4:00pm. However, a 3% credit card transaction fee will be deducted from the refund if the balance was paid by a credit card.
There is **NO** cancellation or refund once an order has been submitted to the lab.

***Warranty Policy*:** There is a one-time redo warranty on lenses and one-year warranty on a new frame against normal wear and tear (discontinued and deep discounted frames are sold as is and carry **NO** warranty). The warranty does not cover damaged due to accident, negligence and abuse.

***Frame Exchange Policy*:** If you are unhappy with your frame, a one-time frame change is allowed within four weeks from the original date of purchase. There will be a $50 charge for handling and processing. Under these circumstances, the warranty on the lenses is void and the warranty on the new frame is good for one year. ***Exclusions apply:** Eye-med insurance does not allow frame exchanges; and Medi-Cal has no warranty on Modern Optical frame.

Frame Waiver: Although we use the utmost care when handling your frames, occasionally, a frame will break in the process of adjusting it, or while manufacturing new lenses. Because we do not have control over theses possible unforeseen factors, we cannot be held responsible for any breakage/ damage to patients own frame.

***Appointment Cancellation Policy*:** We are committed to providing exceptional care. Unfortunately, when one patient cancels without giving enough notice, they prevent another patient from being seen. **Please call us at 707-554-1773 by 2:00 p.m.** on the day prior to your schedule appointment to notify us of any change**s** or cancellations. To cancel a Tuesday appointment, please call our office by 2:00 p.m. on Friday. **If prior notification is not given, you will be charged $50 for the missed appointment.**

***Special Services*:** Appointments made for special services that require extra chair time (CRT lens fitting/ check, Vision Efficiency Evaluation and/or Vision Therapy sessions) are subject to policies on signed contracts and scheduling/ re-scheduling can be discussed prior to services rendered.

I have read and understood the above policies.

Print Name:_____

Signature:_____**Date:** _____