Acknowledgment Of Receipt

☐ I have acknowledged that I have received and read the Notices of Privacy Practices of In Focus Eyecare

☐ I have received, but not read the Notice of Privacy Practices of In Focus Eyecare but would like to continue my eye care at this office

☐ I will not sign the Notice of Privacy Practices of In Focus Eyecare an choose to seek another eye care provider

☐ Due to extenuating circumstances, I am unable to sign the form at this time, but would like to continue my eye care at this time

Patient name: _____
(Please print)

Patient Signature: _____
(Parent of guardian, if patient is a minor)

Date: _____

Payment Policy

Payment is expected at the time services are rendered. Contact lenses require payment prior to ordering. Glasses require full payment prior to dispensing. Uncollected fees whether insurance, insufficient funds, check stop payment, credit card charge backs, etc.... remain the responsibility of the patient. (Parent of legal guardian, if a minor). When insurance benefits are verified, the information provided by the customer service representative is NOT a guarantee of payment. There may be addition fees for co-pays, deductibles and non-covered services after payment is received from the insurance company. By signing this statement, you agree to be financially responsible for any and all charges. In addition, you agree to pay all fees incurred to collect on your account if necessary. Unpaid balances accrue interest at the rate of 1.5% monthly (18%APR).

Assignment of benefits (only applicable if we are filing with a vision or medical insurance for you)

I hereby authorize my insurance/medical benefits to be paid directly to Dr. Mano G. Valderaz. I further authorize release of any medical records or information necessary to process this claim.

_____ _____
Patient/Legal Guardian's Signature Date