AUTHORIZATION

60 DAY POLICY

Initial

____ I UNDERSTAND THAT AS A COURTESY, GLASSES OR CONTACT LENS FIT /VISION RELATED FOLLOW-UPS ARE PROVIDED AT NO CHARGE FOR **60 DAYS FROM DATE OF INITIAL EXAMINATION ONLY**. AFTER THIS TIME, FULL CURRENT PROFESSIONAL EXAM FEES WILL BE ASSESSED FOR A NEW EXAM. I UNDERSTAND THAT THE GLASSES OR CONTACT LENS PRESCRIPTION THAT I RECEIVE FROM MY EXAM DOES NOT HAVE ANY WARRANTY OR GUARANTEE ASSOCIATED WITH IT, AS MY EYES CAN CHANGE AT ANY TIME.

HIPAA AUTHORIZATION

Initial

____ I ACKNOWLEDGE THAT BY REQUEST I MAY RECEIVE A COPY OF THE NOTICE OF PRIVACY PRACTICES FROM THE OFFICE OF ALI, OD AND PATEL, OD, POC. I HEREBY AUTHORIZE THE RELEASE OF ANY MEDICAL/VISION RECORDS OR ANY OTHER INFORMATION NECESSARY TO PROCESS INSURANCE CLAIMS AND/OR TO OTHER PRACTITIONERS OR OPTICIANS INVOLVED IN MY CARE. IF USING INSURANCE, I ALSO AUTHORIZE PAYMENT BY THIRD PARTY PAYERS TO ALI, OD AND PATEL, OD, POC FOR SERVICES PROVIDED AND UNDERSTAND THAT I AM RESPONSIBLE FOR PAYMENT OF SERVICES NOT COVERED UNDER MY INSURANCE PLAN, OR IN THE EVENT THAT ONLY PARTIAL OR NO PAYMENT IS RECEIVED WITHIN 60 DAYS OF INITIAL SUBMISSION OF MY CLAIM.

FINANCIAL RESPONSIBILITY

Initial

____ I UNDERSTAND THAT PAYMENT IS DUE AT THE TIME THAT SERVICES ARE RENDERED AND THAT I AM RESPONSIBLE FOR PAYING FOR ALL SERVICES RENDERED. I UNDERSTAND THAT ALL FEES ARE FOR PROFESSIONAL SERVICES PROVIDED ONLY AND DO NOT INCLUDE THE COST OF GLASSES, CONTACT LENSES, PHARMACEUTICALS OF ANY KIND (OVER THE COUNTER OR PRESCRIBED), OR ANY OTHER MEDICAL OR VISUAL DEVICES OF ANY KIND.

PATIENT NAME:_____ **SIGNATURE:**_____**DATE:**_____