

Please discontinue use of your cell phone while Dr. Kingsley is seeing you in the exam rooms

In order that we may better serve you please read and sign the following policy statement. If you have any questions, please let us know.

I, the patient or responsible party, authorize Dr. Daniel Kingsley and staff to render vision services to the patient or myself.

Materials: A non-refundable deposit of one-half the cost of your materials must be paid when order is placed. The balance is due in full when order is picked up. If not picked up a product restocking fee may be applicable.

Contact Lens Fitting: Includes exam, fitting session, and two follow-up visits. There **will** be a charge for additional follow-ups.

Tonometry: We measure your eye pressure, which is an important part of assessing ocular health by applanation tonometry. This procedure requires an instrument to touch the eye. During this procedure, you must sit very still and follow the doctor or technicians instructions. Failure to do so may result in a corneal abrasion.

Insurance: I authorize Dr. Daniel Kingsley and staff to bill my insurance company when applicable. If any problem arises with my insurance company payments, I understand it will be my responsibility to pay Dr. Kingsley directly. This is also true if you fail to provide your current insurance information at the time of initial visit. If you do not have insurance, we require payment in full at the time of visit. All insurance co-pays are due at the time of service in full. Any balance after insurance payment(s) must be paid within 30 days. Those who have not met their deductibles are responsible for their entire bill at time of service. In the case where an insurance company overpays us, and you are due a refund, a check for the refund amount will be mailed to you. No checks will be issued during business hours.

Collection: In the event this account is turned over to a collection agent, I agree to pay all costs of collection, including but not limited to, attorney's fees, court costs, interest determined, and product restocking fees.

Emergencies: We recommend that if you have a vision emergency outside our operating hours that you proceed immediately to the nearest emergency room.

PLEASE BE SURE TO FILL THIS SECTION IN COMPLETELY

Date: _____

Patient Name: _____ S.S.#: _____
Printed

Responsible Party: _____ Relationship to Patient: _____

Telephone#:(____)-____ - _____ ext _____ Email address: _____

Address of Responsible Party/Patient

mailing address

physical address if not same as Mailing address

Place of employment: _____ Work#: (____)-____ - _____

Full address of employer: _____

I understand it is my responsibility to furnish Dr. Kingsley with changes to insurance, address, telephone number, and place of employment. I have received a copy of the privacy act (HIPPA).

Signature

Printed Name