EyeCare Associates, P.C.
Dr. Stephen Carr
Dr. Randy Schulman
Dr. Narvan Bennett
Dr. Brian Rodrigues

VISION SERVICE INSURANCE RELEASE

Patient Name: _____

I agree to provide all necessary referral forms for vision services. I understand that my Insurance Company may or may not cover part or all of vision services. I agree to assume responsibility for payment of services rendered which have no referral form or have been denied by my insurance company.

I also agree to assume responsibility for any outstanding balance over 60 days past due by my insurance company. I understand that if payment is received after I have paid for service, I will be refunded within 14 business days of insurance payment.

CANCELLATION POLICY

We encourage regular vision examinations to monitor the health of your eyes. Due to the high volume of patients we have, we ask that if you need to cancel an appointment, you kindly give us 24 hours notice if possible. We have a cancellation list for patients who would like appointments.

A $50 fee will be charged in the event of not showing for an appointment or failing to give 24-hour cancellation notice.

Signed: _____

Date: _____

CREDIT CARD AUTHORIZATION FOR CONTACT LENS SALES / VISION SERVICES

I authorize that my credit card information listed below be kept on file and used for outstanding balances including contact lens orders and/or vision services.

Credit Card (Visa/MC) # _____

Exp. Date: _____ V-Code: _____

_____
Signature Date