AGREEMENT FOR PAYMENT OF SERVICES AND ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

Patient Name: _____ Patient DOB:_____

PAYMENT FOR SERVICES RENDERED: I acknowledge that if I do not have insurance, that payment is due at the time of service. Otherwise, I understand that Johnson Eyecare and Eyewear will bill my insurance carrier and accept payment in accordance with my most recent vision exam, special testing, surgical procedures and/or purchase of glasses or contacts. I also understand that Johnson Eyecare and Eyewear may not be familiar with my insurance benefits or be able to fully determine whether my insurance company will pay for all or part of my services. In the event that my insurance does not provide full reimbursement to Johnson Eyecare and Eyewear, I agree to be responsible for any charges beyond my plan allowance, co-insurance or any deductible that may apply. The amount calculated on the day of purchase/service will be seen only as an estimate of my responsibility toward that purchase/service resulting in an overpayment, which will be refunded to me, or an underpayment, which will result in a balance due by me at a later date. Any out-of-network insurance plan, will be processed at an out-of-network level and may require a higher co-payment, co-insurance or deductible in which I will be responsible for payment out of pocket. Full payment may be required at the time of visit.
I understand that Lenses are a medical prescription. A refund cannot be issued once lenses have been cut to fit my chosen frame unless accompanied by a Doctor's recent change of prescription.

NOTICE OF PRIVACY PRACTICES: The law requires that Johnson Eyecare and Eyewear make every effort to inform you of your rights related to your personal health information. By my signing below, I have acknowledged that

☐ I have read, had explained to me or was given the opportunity to read, Johnson Eyecare PC's Notice of Privacy Practice and agree to continue my care with Johnson Eyecare PC under said terms

☐ *I have read or had explained to me Johnson Eyecare's Notice of Privacy Practice and do **NOT** wish to continue my care with Johnson Eyecare PC under the said terms*
☐ *The notice of Privacy Practice could not be read due to the emergent nature of the care of the other reason as described as* _____

My signature below authorizes the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all my insurance submissions for this calendar year. My signature also signifies that I have or acknowledge Johnson Eyecare PC's Notice of Privacy Practices.

_____ _____
Signature of patient or responsible party Date

_____
Print Name of Responsible Party (if other than patient)

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