Robert E. Reid, O.D.

Family Eye Care Center, Inc.

OFFICE POLICIES AND PROCEDURES

This letter is to acquaint our patients with our general office policies and procedures as well as to avoid any misunderstandings. Please initial at each point and sign at the bottom after reading and understanding what is written below.

_____1.) Our responsibility is to only you, the patient. We practice optometry and stress the importance of regular care to help you in our goal to achieve and maintain your proper eye health. We care about you and your eye health.

_____2.) **50%** down payment is required when ordering glasses or contact lenses. Payment in full is required upon the dispensing of the glasses or contacts. Contact lenses shipped directly to the patient must be paid in full before they are ordered and shipped.

_____3.) Product not picked up within 60 days of ordering may be subject to a $10 handling fee. Product not picked up within 90 days of ordering will be sent back and is subject to a 15% restocking fee in addition to any additional charges incurred by the return of the product to the lab.

_____4.) Although we honor vision insurance, the payment of services is the responsibility of the patient or the guardian - not the insurance company. If you have VISION INSURANCE, it is your insurance benefit and you need to understand it. We are not responsible for knowing the details of your insurance. We are here to help you approximate your co-payment of each office visit. We do expect co-payments on each visit ranging between 20% - 50% of the total services rendered (which may include a deductible).

_____5.) If you have Vision Insurance, it is your responsibility to bring a completed insurance form with you or a valid vision card for each visit. ALL BALANCES are due and payable in thirty days by the patient or legal guardian.

_____6.) Third party custody arrangements: This office cannot be a party of such arrangements. Therefore, the total bill for the minor patients is the responsibility of the parent/guardian who brings the child to the office. Insurance claims will be submitted but co-payments are due at each visit as stated above.

_____7.) Should a balance in your account occur, the net is due upon receipt of a billing statement. Amounts not paid by the next billing date are subject to a monthly re-billing charge of 3%. Three statements will be sent before collection procedures will start. If a credit should occur on your account after all insurance payments are in, we will gladly refund the difference to the patient or leave the credit on your account as a co-payment for future office visits.

_____8.) We also honor VISA, MASTERCARD, DISCOVER, and AMERICAN EXPRESS as payment. Special payment plans can be arranged through our office manager.

_____9.) We ask that our patients please give us at least 24 HOURS notice when rescheduling an appointment. BROKEN appointments will not be tolerated. Please be aware that a $25.00 charge for broken appointments may be assessed.

Our goal is to make your vision appointments as comfortable and pleasant as possible. If you have any questions, please feel free to discuss them with the Doctor or Office Personnel.

_____ _____

PATIENT SIGNATURE DATE