ADVANCED EYECARE
Robert Palozej, OD • Matthew Palozej, OD

Acknowledgement, Financial Policy & General Consent Form

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES:

By my signature below, I hereby acknowledge that I have been offered a copy of the Practice's Notice of Privacy Practices. I understand I may revoke this consent at any time, by making a request in writing, except for information already used or disclosed.

By my signature below, I authorize the practice to communicate with me by phone, text, or email, and to leave general messages on my answering machine or by voicemail. I also consent to my information to be disclosed to the following people: _____

CONSENT TO TREATMENT:

By my signature below, I do hereby voluntarily consent to treatment by optometrist of the practice for an eye exam and to any related diagnostic procedures and treatments as necessary in the judgement of the optometrist. I acknowledge that eye exams are not always routine in nature, and at the discretion of my optometrist, my medical insurance may be billed accordingly.

INSURANCE BILLING POLICY:

By my signature below, I understand that Robert R. Palozej OD, LLC. will bill my insurance on my behalf to carriers which they are providers for. I understand that the practice cannot guarantee anything regarding my insurance, as it is a contract between me and the insurance company, not with the office. The office will do it's best to provide as much information as possible, but I understand it is my responsibility to know my insurance and benefits. I understand it is my responsibility to obtain any referrals or prior authorizations as necessary, and I am responsible for any balances owed due to a lack of referral or prior authorization.

CONTACT LENS POLICY:

By my signature below, I understand that contact lenses are a separate service from an eye exam, and I agree to pay any fees associate with obtaining a contact lens prescription. I acknowledge that contact lens prescriptions expire annually, in compliance with Connecticut state law, and if I choose not to update my prescription, I will not be able to order contact lenses in the future.

FINCANCIAL POLICY:

By my signature below, I understand that payment for all services is expected at the time of service. A fifty percent deposit is required for all eyewear orders, and I understand that glasses and contact lenses must be paid for in full when products are dispensed. If I cannot do so, I understand I may not be able to leave the office with the products, unless arrangements are made with the office manager or Dr. Robert Palozej.

By my signature below, I agree to all of the above while I am a patient of the practice.

_____ _____

Signature of Patient or Personal Representative **Date**