ADVANCED EYECARE
Robert Palozej, OD • Matthew Palozej, OD
19 Pinney Street • P.O. Box 351 • Ellington, CT 06029
Phone: (860) 875-7336

Acknowledgement, Financial Policy & General Consent Form

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES:
I hereby acknowledge that a copy of Advanced Eyecare's Notice of Privacy Practices is available in the waiting room of the office or online at AdvancedEyecareEllington.com. I understand I may revoke this consent at any time, by making a request in writing, except for information already used or disclosed.

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.

CONSENT TO TREATMENT:
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:
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:
I understand that contact lens fittings are a separate service from an eye exam, and I agree to pay any fees associate with obtaining and renewing a contact lens prescription, regardless of if my prescription has changed. 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. I understand that if I have an open balance on my account, I will be required to pay this prior to receiving a copy of my contact lens prescription.

FINANCIAL POLICY & CANCELLATION POLICY:
I understand that payment for all services is expected at the time of service, and I am responsible for any balances not covered by my insurance. 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. Palozej. I understand that cancelling my appointment with less than 24 hours' notice or no-showing for an appointment will incur a $75 fee.

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**

_____

Patient's Name (Please Print)