Trussville Vision Care

The following is our Policies & Procedures which you need to understand prior to treatment.

_____ I consent to the Optos digital retinal imaging photo in lieu of dilation. There is a $34 fee for this photo. **INSURANCE WILL NOT PAY FOR THIS PHOTO SO IT IS OPTIONAL.**

_____ I understand that contact lenses are a separate part of my eye exam. A "new fit" fee of $100 is charged initially & a $50 evaluation fee will be charged YEARLY thereafter. This evaluation will cover any subsequent visits within a 90-day period. Charges for fitting &/or evaluations are due IN FULL at the time of service.

_____ I understand that I may be charged a $25 fee after CONSECUTIVE non-cancelled appointments.

_____ I understand that I will be responsible for all copays due IN FULL at the time of service. It is MY RESPONSIBILITY to know the limits of my coverage and to pay any fees that my insurance company denies. (We accept cash, checks, and most major credit cards. There will be a $30.00 fee on all returned checks.)

_____ I understand that any necessary medical testing conducted during a regular exam will be billed under my major medical insurance (medical tests are NOT covered by any vision plans). I understand that I will owe my medical copay for these tests at the time of service, as well as any yearly deductible amount returned from my insurance.

_____ I authorize the release of medical information to my primary care or referring physician if needed or requested.

_____ I am aware that the practice has a Notice of Privacy Policies that contains a section on Patient Rights. I have been given the opportunity to review this notice (if requested).

Patient or Responsible Party (signature): _____ Date: ___ / ___ / ___