Visualize Optometry

Name of Patient:

(Last) (First)

General Financial Policy

1. I acknowledge that I am fully responsible for all costs incurred during my treatment at Visualize Optometry.
2. I understand payment is due in full at the time I receive service.
3. I understand there are no refunds available on professional services, or diagnostic testing.
4. I understand there are no refunds offered on contact lenses received by me.
5. *I understand that for all check and credit card purchases the account holder must be present.*
6. I understand that a Collection Agency may be used to collect unpaid balances. I further agree to pay any and all legal collection costs on my account.

SIGNATURE_____ DATE_____

(Patient, Or parent/legal guardian if patient is a minor)

Insurance Financial Policy-(Only if using insurance)

Visualize Optometry is currently filing insurance claims with Superior Vision, most Davis Vision plans and Vision Service Plan (VSP) out-of-network.

Name of Insured:

(If other than patient) (Last) (First)

1. I understand that as a service, Visualize Optometry may file my insurance claim. In order to do so I am required to supply Visualize Optometry with my Social Security number **or** my assigned identification number.
2. I understand that my insurance coverage is a contract between myself and the insurance company and Visualize Optometry is not a party to that contract. If my insurance company does not pay in a timely manner (60 days), I will be responsible for payment of the charges incurred.
3. I understand and agree that all insurance deductibles and any incurred expenses not covered by the insured's health carrier must be paid for at the time of the office visit.
4. I agree to pay Visualize Optometry (in full) within 30 days of notification of nonpayment by my insurance carrier.
5. I hereby authorize payment directly to Dr. Fritz Rohrakste, Dr. Randal Carter, Visualize Optometry and all associates of Visualize Optometry for all services rendered to me.
6. I authorize a copy of this "SIGNATURE ON FILE" form to be used in place of the original and that this copy may be used on all my insurance submissions.

SIGNATURE_____ DATE_____

(Patient, Or parent/legal guardian if patient is a minor)