Responsibility Statement

Your insurance is a method for you to receive reimbursement for fees you may have paid C&C Vision Gallery, for services rendered. Having insurance is not a substitute for payment. Many companies have fixed allowances or percentages based on your contract with them and not with our office. It is your responsibility to pay in advance for the deductible, coinsurance, or any other balance not paid for by your insurance. We will assist you in receiving as much reimbursement as possible; however, you are responsible in advance for your bill.

Examination fees and all copayments are due at the time of service. All products must be paid in full before they are ordered. Refunds will not be given on services, contact lenses, or customized ophthalmic materials including progressive upgrades.

C&C Vision Gallery provides exceptional contact lens services. If you are interested in contact lenses or currently wear contact lenses, the doctor can discuss your options with you. Our recommendations are individually tailored to each patient and are based on many factors that require additional testing and expertise. For this reason, insurance companies do not consider the evaluation to be part of the routine comprehensive examination and require that the evaluation fees be separate from the exam. Additional service fees for evaluations may not be covered by your insurance and are due at the time of service. Evaluations must be performed every year in order to have a valid contact lens prescription. For more information about contact lens evaluations, please refer to our informational form located in the waiting area and/or speak to your technician prior to exam.

Financial Responsibility

By signing this statement you agree to be financially responsible for all charges. If an account goes unpaid, a finance charge of 5% per month is applied to balances 60 days past due. A fee up to 33.33% is added to accounts sent out to Collections. All returned NSF checks will be charged a service fee of $40.

Authorization to Release Medical Information

I authorize C&C Vision Gallery to release/request medical information on my behalf to/from any entity to assist in my medical care per my request. I also authorize my insurance carrier to make payment directly to C&C Vision Gallery. This assignment will remain in effect until revoked in writing. A photocopy of this assignment is considered to be as valid as the original.

Patient or Guardian Signature	Relationship to Patient	Date

HIPPA Acknowledgement **(Copy available in lobby)**

I acknowledge that I was provided the opportunity to receive/review a copy of the HIPPA Privacy Policy Notice.

Patient or Guardian Signature	Relationship to Patient	Date