

OFFICE POLICIES / CONSENT FORM

We require payment in full on all contact lenses and glasses before the order can be placed.

If you are unable to attend your appointment , our office will appreciate a 24-hour cancellation notice.

Our staff must verify your benefits before your scheduled appointment. If benefits have not been verified, you will be responsible for paying all fees today. As a **courtesy** to our patients we will submit claims for you to your insurance carrier. Information obtained about your benefits is not a guarantee of payment from your insurance company. **You are responsible for any amount not paid by the insurance company for any reason.** If payment is denied, it is up to you, the subscriber, to resolve the issue.

In order to purchase contact lenses, you must have an exam and evaluation every year in accordance with **Georgia State Law**. These charges range between **\$60.00 - \$76.00** beyond the fee for the routine eye exam. First time wearers will be charged an additional **\$20.00** for the proper training of the insertion and removal and care of their contact lenses. The majority of insurance companies **DO NOT** cover these charges. **This is payable at the time service is rendered. A prescription for contact lenses is not given until all money owed is paid and the doctor has finalized the prescription.**

Your co-pays are due at the time of your visit. As a **courtesy** we will submit this to your secondary insurance company. If we receive any payment from them, a refund will be issued.

Any account over **30 days** old will immediately be sent to **collections**. There will be a **\$25.00 processing fee added to the balance**. Any money deposited will be **forfeited**, and materials will be donated.

There will be a charge of **\$25.00** for all returned checks and the account will be sent to collections within **10 days**.

I hereby give my consent for the Office of Dr. Mark A. Gottlieb to use and disclose protected health information about me to carry out treatment, payment and healthcare operations.

Signature of Patient or Responsible Party

Today's Date

Print Name of Patient