Patient Name: _____ **DOB:** _____

GOLDEN OPTOMETRIC

STATEMENT OF FINANCIAL RESPONSIBILITY

GOLDEN OPTOMETRIC appreciates the confidence you have shown in choosing us to provide for your health care needs. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill.

You are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. We expect these payments at time of service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. If your insurance carrier denies any part of your claim, or if you or your optometrist elects to continue past your approved period, you will be responsible for your balance in full.

I have read the above policy regarding my financial responsibility to GOLDEN OPTOMETRIC, for providing eye care services to me or the above named patient. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to GOLDEN OPTOMETRIC, the full and entire amount of bill incurred by me or the above named patient; or, if applicable any amount due after payment has been made by my insurance carrier.

CO-PAY POLICY: Some health insurance carriers require the patient to pay a co-pay for services rendered. It is expected and appreciated at the time the service is rendered for the patients to pay at EACH VISIT.

CONSENT FOR TREATMENT & AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize GOLDEN OPTOMETRIC, through its appropriate personnel, to perform or have performed upon me, or the above-named patient, appropriate assessment, and treatment procedures. I further authorize GOLDEN OPTOMETRIC to release to appropriate agencies, any information acquired during my, or the above-named patient's, examination and treatment.

EXCHANGE POLICY

PROFESSIONAL SERVICES: Professional fees (examination, refraction, contact lens fitting/ evaluation, or any services performed "by the doctor") are not refundable.

FRAMES: Within 90 days of the order date, if you are not fully satisfied with your frame purchase, we will credit the full amount paid for the frame towards the purchase of a new frame. Excluding frames included in discount packages, all frames have a limited, single use 12-month warranty from the date of purchase for frame manufacturer defects. Any alterations or gluing of frames will void the warranty. Defective frames will be replaced for a $25 processing fee. Premium frames include the same warranty but are processed at no cost. Please note, due to insurance regulations, frame exchanges may not be allowed.

SUNGLASSES: All non-prescription sunglasses may be exchanged within 14 days of purchase. They must be returned in new condition and with the original case. Full credit will be applied to the patients account to be used toward future purchases. Unfortunately, no refunds can be issued.
Maui Jim, Oakley, and Costa lenses are specialty lenses that are custom made in their own labs. They can only be exchanged for a frame and lens set within the same product line.
Exchanges can only be made within 45 days of the date of purchase. If progressive lenses have been ordered, and there is a non-adapt issue, we will remake the lenses to single vision at no additional cost to you. However, no refunds can be issued due to expenses incurred by the laboratory.

LENSES: All lenses are custom made. Any cancellation within 30 days of the order date will be refunded up to 50% of the Usual and Customary lens fee. If progressive lenses have been ordered, and you cannot adapt to them, we will gladly remake them to single vision, bifocal or trifocal lenses at no additional costs. Refunds will not be issued due to already incurred expenses by the laboratory.
Within 30 days, if you are not satisfied with your prescription or lenses, please call the office and speak with an optician to help you with this matter. Excluding lenses included in discount packages, all lenses include a limited, single use 12-month warranty from the date of purchase for damage to your lenses. Damaged lenses will be replaced for a $25 processing fee. Premium lenses include the same warranty but are processed at no cost.

CONTACT LENSES: Unopened, undamaged, unmarked, and unexpired contact lens boxes may be exchanged or returned for full credit toward the purchase of contact lenses or eyewear within one year from date of purchase.

We offer unlimited cleanings and adjustments for any glasses purchased in our office at no extra charge.

My signature below attests that I have read and agree to the **FINANCIAL RESPONSIBILITY** and **EXCHANGE POLICY** terms:

Patient Signature _____ Date _____

Guarantor Signature _____ Date _____
(If guarantor is not the patient)