# CONCORD FAMILY VISION CENTER, PLLC

## DOCTORS OF OPTOMETRY

JOSEPH P LAROCHELLE, OD ♦ CHRISTOPHER P UDINA, OD

**PATIENT NAME:** (print) _____

I authorize payment of medical benefits to one of the providers listed above, for professional services rendered.

**I am aware that I will be responsible for any amount not paid for by my insurance.**

For services provided without a referral authorization (if needed): I acknowledge that I do not have a referral today and will be responsible for payment of services should this be denied by my health plan.

**For Medicare patients**: Medicare does **not** cover eyeglasses or exams for eyeglasses.
There will be a charge at time of service to cover the eyeglass refraction.

I authorize the release of medical information necessary to process my claims.
I authorize the release of any insurance information and diagnosis codes to any lab used for my care.

Office policy is to give out your information only with your written approval.
Please list anyone you wish us to share your medical information with below:

_____ _____

**FINANCIAL POLICY**

Copayments are due at the time of service as required by ALL insurance plans.
We do participate with most insurance plans, but not all. We cannot be sure until we see your insurance card. If you require a referral for medical visits, it is your responsibility to obtain the referral.

50% of balance on spectacle orders must be paid before order will be processed. Remaining balance must be paid at pick up. A 20% discount will be given for all orders paid in full at time of order. Contact lens orders must be paid in full at time of pick up.

Our office accepts cash, checks, VISA/MASTERCARD, and DISCOVER as payment. We will charge additional fees for all returned checks.

We reserve the right to charge patients $50 each time they do not show for their scheduled appointment or cancel an appointment with less than a 24 hour notice.

Patient Signature: _____ Date: _____