DUPAGE OPTICAL
"OUR VISION IS TO HELP YOURS" PROVIDING ADVANCED EYE CARE SINCE 1957

For office use only: _____

PATIENT INFORMED CONSENT OF POLICIES
PAYMENT IS DUE IN FULL AT TIME OF SERVICE

BENEFIT ASSIGNMENT:

The assignment of benefits of any insurance policy and/ or healthcare reimbursement plan shall not be deemed a waiver of DuPage Optical's right to require payment directly from undersigned, the patient or the guardian.

BILLING INFORMATION:

As a courtesy, DuPage Optical files claims directly to your medical insurance or vision plans (in most cases). It is your responsibility to verify your benefits and provider network coverage. If you have questions about your plan benefits, please contact your medical or vision plans directly. It is your responsibility to provide DuPage Optical with correct information including insurance, pre-certifications, responsible party, date of injury, type of accident, policy and/or group numbers, etc. Should the information change, it is your responsibility to update it within a timely manner. If you supply DuPage Optical with incorrect information, the balance of the account at the last date of service will be entirely patient responsibility. DuPage Optical will not be responsible for rebilling, appealing or other dealings with newly provided insurance company.

If your balance becomes 90 days or more overdue, our office reserves the right to refuse appointments and we will send your account to a collection agency for collection. In the event that your account is sent for collection, you will be responsible for all cost and fees, including reasonable collection agency fees.

This policy is subject to change without notice.

METHODS OF PAYMENT:

DuPage Optical accepts cash, credit cards, debit cards, Care Credit and personal checks as methods of payment. There is a fee of $30.00 for any checks returned by your bank. Checks shall be written to DuPage Optical.

REFUND POLICY:

Eyewear refunds – There will be a restocking fee of 25% of the total cost of the eyewear if returned within 30 days, 50% within 90 days. No refunds after 90 days.
Doctor Changes – Lenses will be remade up to 90 days from the date of the original receipt at no cost and at 50% of the original cost of lenses thereafter.
Contact Lens – Custom made lenses will have restocking fee of 25%.
Boxed Lenses – full refund if unopened and unexpired.

MISSED APPOINTMENT FEE:

DuPage Optical requires at least a 24 hour notice to cancel an appointment. You may be charged a Late Cancellation/No Show fee of $25.00. This fee is not billable or payable by insurance. Patients with more than three missed appointments will not be able to schedule appointments without a deposit of $25.00 to be applied at newly scheduled appointment. We understand that emergencies do occur and will attempt to make reasonable accommodations for that. If the appointment can be made up within the week of the missed appointment, the $25.00 fee will be waived.

WAIVER OF CONFIDENTIALITY:

You understand if this account is submitted to an attorney or collection agency or if you're past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

I have been informed of my financial responsibility and agree to the terms and conditions as stated on this form. I understand that my health insurance policy is a contractual agreement between my insurance carrier and me. It is therefore my responsibility question my insurance company regarding delays in payment and/or denial of coverage, incorrect processing of claims by the insurance company, as well as any requirements that may be included in my insurance policy coverage (i.e. Pre-certifications, in-network status, referrals, co-insurances, and deductibles).

Patient Name (print): _____

Responsible Party (print):_____

Patient (Representative) Signature: _____Date: _____/_____/____

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

I acknowledge that I have received DuPage Optical's Notice of Privacy Practice. (A copy of our Privacy Practice is available at the front desk). I understand that my data may be shared with other healthcare providers who are associated with my medical care.

_____ _____
Signature of Patient (or Patients' Representative) Date

_____ _____
Patient Name (Print) Patient Date of Birth

_____
Patient Representative (Print)

If person signing is a representative, describe relationship to patient:

_____

DuPage Optical has my permission to leave information regarding my medical condition on my:

- ☐ Home Answering Machine (_____) _____ - _____
- ☐ Cell Phone (_____) _____ - _____
- ☐ Work Voice Mail (_____) _____ - _____

DuPage Optical has my permission to communicate my health information and release any materials to the following individuals:

Name: _____ Relation to Patient: _____ Phone #:_____

Name: _____ Relation to Patient: _____ Phone #:_____

Name: _____ Relation to Patient: _____ Phone #:_____