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www.mindeyeconnection.com
BRIDGING THE GAP BETWEEN NEUROSCIENCE AND EYE CARE

Patient's Financial Responsibility

Please PRINT on lines that do not require a signature.

Patient's Name: _____ Patient's DOB: _____

Responsible Party: _____ Responsible Party's DOB: _____

Responsible Party's Social Security Number (SSN): __ __ __ - __ __ - __ __ __ Relationship to Patient: _____

Signature of Responsible Party: _____ Date: _____

By signing above, you are indicating that you are aware of and agree to abide by the following policies:

Cancellation / No-Show Policy

The Mind-Eye Connection requires 48-hours notice of any necessary appointment cancellation. In the event that you are unable to provide the office with a 48-hour notice of cancellation, a "No-Show/Late Cancellation" fee of $75.00 will be assessed. Please call the office if you anticipate arriving 10 minutes or later than the scheduled appointment time. **If you fail to notify the office and arrive 20 minutes after the scheduled appointment time, you will be counted as a "No-Show."**

At the Mind-Eye Connection, we are sensitive to the unexpected nature of illness and emergency. Exceptions to this policy MAY be made on a case-by-case basis.

Payment for Services and Materials

Payment is due in full at the time services are rendered or materials are received, including, but not limited to: exams, reports, frames, lenses, contact lenses, and equipment. There are no refunds on services, opened contact lenses, glasses lenses, and/or glasses frames. Manufacturers warranty frames for manufacturing defects only, and provide only one warranty replacement within one year of date of purchase. Mind-Eye Connection offers 35% Discount on additional sets of glasses lenses when prescription is adjusted for therapeutic reasons within 6 months of original purchase and at doctor's discretion.

Returned Check Fee

Any check submitted for payment but returned to the office will incur a $35.00 fee. Each instance will result in an additional fine, and may result in the office's refusal to accept personal checks as payment.

Payment Plans

Our office will be happy to work with you in order to arrive at mutually acceptable terms to pay any balance due to our practice. Please see the office manager or the accounting representative if you would like more information.

Collections and Outstanding Balances

Unless prior arrangements have been made, a $15.00 processing fee will be assessed monthly and added to any unpaid balance. Additionally, any outstanding balance after 60 days of the date of service may be referred to an outside collection agency. Accounts referred to an outside collection agency or attorney may be subject to a collection fee of $25.00, which will be added to the total balance due at the time of write-off. Patients with unpaid delinquent accounts or accounts which have been sent to collections may be discharged from this practice.

Keeping a credit card on file

It is our practice's policy to keep a credit card number on file to be used for any unpaid balances. This is the same process you would go through for hotels, rental cars, etc. Your information will be kept safe and confidential. We appreciate your cooperation.

Credit Card Number: _____Exp:_____ Billing Zip Code:_____

Cardholder's Name (Print):_____ Cardholder Date of Birth_____

Cardholder's Signature: _____ Date Signed: _____