ALL EYES VISION CARE
REBECCA SOSEBEE, OD

Please read and initial each paragraph, and sign at the bottom.

_____ Welcome to our optometry office. We appreciate the opportunity to assist you with all your eye care needs and concerns. Our goal is to provide you with the best care in an efficient and professional manner. Together we can accomplish this goal. Like any business we have office policies that we must adhere to so that we can operate in a manner that will benefit our relationship. We will define those policies in the next couple of paragraphs.

____ All co-pays are due at the time of treatment. Our office will file and collect insurance claims if we are contracted providers with that insurance company. We do our best to verify insurance and benefits before services are rendered. However, if your insurance is canceled or you provide incorrect information to us about your insurance, you will be held responsible for the entire balance owed. Upon request, we will supply you with a copy of the claim so that you can resubmit as necessary.

____ We must have a 24-hour notice should you be unable to come to your appointment. We will make every effort to confirm your appointment with you; however, it is your repsonsibility to keep up with your appointment time. **Failure to give us 24-hour notice will result in a $30.00 broken appointment charge billed to your account.** We have reserved this time for you and must know if you will able to keep it.

____ All return checks, stop payments and credit card charge backs incur a fee of $30.00

____ All products sold in our office are non-refundable.

____ We try very hard to adhere to a schedule. If you are more than 10 minutes late, we may have to reschedule your appointment. Sometimes an emergency will occur that will make us run behind, please be patient with us as it could be you with that emergency. We do respect your time and make every effort to stay as close to your appointment time as possible. We thank you for choosing our office and look forward to a long relationship with you and your family.

____ I have read and understand the Notice of Privacy Practices attached.

I understand and agree to the above practice policies.

Patient/Guardian Signature if under 18 **Date**