Bonham Optical
1230 N Center St
Bonham, TX 75418

Bonham Optical Policies:

Lab: Our office is not responsible for any items left over 30 days after the completion of the order. If you choose to use your own frame or lenses, we cannot be responsible for any damage that may occur during the mounting, edging, tinting or dispensing process. If you need an adjustment, and the frame is no longer under warranty, we cannot be responsible for any breakage or damage that may occur during this process.

Pupillary Distance: Pupillary distance is not a required part of the prescription in the state of Texas. We do not provide it on the prescription, it is the patient's responsibility to collect this information.

Refund: We have a no refund, no cancellation policy. All lenses are custom made according to your prescription. We will be glad to work with you on any issues that may occur during the first 60 days.

Payment: Payment is expected as services are rendered. All exam copayments and out of pocket expenses must be paid for All glasses and contacts MUST be paid for before we can release them to you. We do not do any form of payment plan.

Insurance: Insurance information must be presented at time of services. No price adjustments will be made after time of service. It is the responsibility of the insured to verify eligibility on all insurance policies prior to their scheduled appointment.

Warranty/Remake: Scratch coat and Anti-Reflective warranty is 365 days, unless your insurance has a specific warranty policy. This warranty does NOT include lost glasses. Frame manufacturer defects are covered up to 1 year after purchase and must be approved by an optician if it is deemed a manufacturer defect.

Progressive Non-Adapt Warranty: The timeframe for non-adapt warranty is 90 days, unless your insurance has a specific non-adapt policy. If you are unable to adapt to the lens, we will provide you new lenses at no charge. No refund on the original purchase will be made. Only 1 non-adapt redo is allowed per patient.

Shipping and Handling: There is a flat fee of $10 to ship any items to you.

Notice of Privacy Practices & Bonham Optical Policies

By signing below, I acknowledge that I have reviewed a copy of the "Notice of Privacy Practices" and "Bonham Optical Policies". Signing below signifies that I agree to the terms and conditions of the agreement stated above.

Patient's Name_____

Signature_____ Date_____

Relationship _____

HIPAA CONSENT

Bonham Optical
1230 N Center St
Bonham, TX 75418
Tel: (903)583-8930 • FAX: (903)583-8138
www.bonhamoptical.com • bonhamoptical@gmail.com

CONSENT TO USE AND DISCLOSE HEALTH INFORMATION

Permission to Use and Disclose My Health Information: By signing this form, I give Bonham Optical permission to use and/or disclose my health information to provide treatment, obtain payment, and/or conduct health care operations.

Right to Refuse: I have the right not to sign this consent. If I refuse to sign this consent, Bonham Optical has the right to refuse to treat me. However, treatment required by law –such as emergency care– can be provided to me whether or not I sign this consent.
Right to Review Notice of Privacy Practices: I have been provided with a copy of the Notice of Privacy Practices for Bonham Optical which describes how Bonham Optical may use and disclose my health information. I have the right to review this Notice before signing this consent.

Changes to the Notice of Privacy Practices: Bonham Optical may change the Notice of Privacy Practices as needed. I may obtain a current copy of the Notice of Privacy Practices for Bonham Optical by contacting Bonham Optical.

Right to Request Restrictions on Use/Disclosure: I have the right to request that the usage of my protected health information by Bonham Optical be restricted in how it is used and/or disclosed for the purpose of providing treatment, obtaining payment, and/or conducting health care operations. However, Bonham Optical is not required to agree to any restriction that I request. If Bonham Optical does decide to agree to my request, the use and/or disclosure of my health information by Bonham Optical must be restricted as I requested. If I wish to request restrictions I can contact Bonham Optical. Bonham Optical will notify me on whether my restrictions have been accepted or declined.

Right to Withdraw Consent: I have the right to withdraw this consent at any time. I must do so in writing by contacting Bonham Optical at 1230 N Center St, Bonham TX, 75418. My withdrawal of this consent will not be effective for uses and/or disclosures that have already been made based on my prior consent. If I withdraw this consent, then Bonham Optical may refuse to provide me further treatment or follow-up, other than required emergency services.

Effective Period: This consent is good unless and until I withdraw it in writing.

References to "I" or "me": References to "I" or "me" in this Consent include the individual for whom the signing party is authorized to sign. If I am signing this consent on behalf of another person, it is because I am that person's parent, legal guardian, or agent under an active Power of Attorney for Health Care; and I am legally authorized to sign this Consent on behalf of that person.

COMMUNICATIONS AUTHORIZATION AND RELEASE OF INFORMATION TO FRIENDS OR FAMILY MEMBERS

LIST NAMES OF FAMILY MEMBERS OR FRIENDS WITH WHOM WE MAY DISCUSS HEALTH CARE ISSUES, MAY PICK UP PRESCRIPTIONS, EQUIPMENT, OR HEALTH CARE INFORMATION:

NAME:_____ RELATIONSHIP:_____

NAME:_____ RELATIONSHIP:_____

NAME:_____ RELATIONSHIP:_____

_____ _____
Signature of Patient or Representative Date

_____
Description of Representative's Authority

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Prescription Release Acknowledgment

Please sign below to acknowledge that you will be provided a copy of your eyeglasses and finalized contact lens prescription (if applicable) after completing your refractive eye exam and all copays are collected.
If your contact lens prescription is not finalized yet, you will receive a copy when finalized.
Signing below also gives consent for prescriptions to be emailed to the patient.

Patient name (Print): _____

Patient/Guardian Signature: _____

Date: _____