Effective date of this notice: August 25, 2017

NOTICE OF PRIVACY PRACTICES

As required by the privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Our office strives to protect your privacy in all phases of care we provide for you. Your records can only be released to another party if you have given our office written permission to do so. This protection covers the release of glasses prescriptions and contact lens prescriptions to another doctor or to the mail order addresses. We must have your written permission on file before we can release your prescription. On file in our office, we have a complete NOTICE OF PRIVACY PRACTICES and you are entitled to a copy of this notice upon request. Please contact the receptionist if you would like a copy.

I authorize the release of any medical or other information to process my insurance claims. I also authorize payment of medical benefits to my doctor. It is my understanding that I am responsible to obtain any and all referrals that my insurance company requires for service performed by that doctor.

By signing below, you show you have been advised of our privacy practices. Also, you do hereby authorize Paris Optical to release a prescription.

Signature:_____ Date: _____

FINANCIAL POLICY

Payment Options: Cash, American Express, Discover, Mastercard, Visa, Care Credit

Please note: Paris Optical requires payment on date of service.[1]

We accept payment of half down at the time glasses or contact lenses are ordered and the balance on the delivery of the glasses or contacts.

Patient has 60 days after placing the order to pick up the glasses or contacts. After 60 days, the product will be returned and there will be a $10 restocking fee added to your account. The fee must be paid and the glasses or contact lenses must be paid in full before any product can be reordered.

NO REFUNDS allowed on all spectacles (frame and lenses) and contact lenses.

We have a no show policy where you will be charged $10 if you do not contact us to cancel or reschedule your appointment 24 hours prior to your appointment time.

For patients with vision insurance, we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement.[2]

_____

Patient, Parent or Guardian Signature Date

_____

Patient Name (Please Print)