Financial Responsibility & HIPAA Acknowledgement

Cancellation Policy

We require 24 hour notice to cancel or reschedule appointments. Failure to do so will result in a $25.00 fee that will be added to your account. This is not payable by insurance.

Initial _____ Date _____

Payment for Services

Payment is due at the time services are rendered. You will be billed for any amounts not covered by insurance. If you DO NOT disclose your insurance benefits to us at the time of your visit, and you later discover that you have benefits, you can submit a claim to your insurance company on your own. No refunds will be issued.

Initial _____ Date _____

Eyewear Sales

Prescription eyeglasses/sunglasses are custom-made for each patient; therefore, all sales are non-refundable.

Initial _____ Date _____

HIPAA Acknowledgement

I hereby acknowledge that I have been given the opportunity to read and/or receive a copy of the Notice of Privacy Practices for Cicero Family Eye Care (located at front desk), which describes how my protected health information may or may not be used.

I consent to Have Dr. Cutre and staff use and disclose my protected health information for submitting claims to insurance companies for payment of services rendered here, for coordination of my health care, or other purposes permitted per HIPAA or other federal and state laws.

Please provide us with who we may disclose information to regarding your appointment, then sign below.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Patient or Guardian Signature: _____

Print Name: _____

Relationship to Patient: _____ Date: _____