Privacy Policy

I acknowledge that I have read and agree to the privacy practices of Hill Vision Center. I furthermore acknowledge that I have the right to request a copy of the privacy policy at any time.

X_____ X_____

Signature of Patient (if over 18) Signature of Responsible Party

Financial Agreement

I acknowledge that I have read and agree to the financial policy of Hill Vision Center. I furthermore acknowledge that I have the right to request a copy of the financial policy at any time.

Late Charges: If I do not pay the entire balance within 25 days of the monthly billing date, a late charge of 1.5% of the balance then unpaid and owed will be assessed each month (if allowable by law). I realize that failure to keep this account current may result in Hill Vision Center being unable to provide additional vision services except for emergent care or where prepayment for additional services is provided. In the case of default payment of this account, I agree to pay the collection costs and reasonable attorney fees in attempting to collect on the amount or any further outstanding account balances.

X_____ X_____

Signature of Patient (if over 18) Signature of Responsible Party

***MEDICARE patients are responsible for a $20 Refraction fee that is not covered by insurance.**

****If you are being seen for a medical reason and a refraction is performed, patient is responsible for the $20 refraction fee that is not covered by medical insurance.**

*****Tricare Prime patients are responsible for all fees if Prior Referral from primary care physician is not obtained.**

Authorization and Release

I authorize the doctor to release any information including the diagnosis and the records of any treatment of examination rendered to me or my child during the period of such optometric care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the optometrist. In the event of denial or rejection by my insurance company, I understand the payment will be my responsibility.

X_____ X_____

Signature of Patient (if over 18) Signature of Responsible Party