Signature on File Form

Lovato Family Optometric Center, Inc.

RESPONSIBILITY STATEMENT

Your insurance is a method for you to receive reimbursement for fees you have paid to the optometrist for services rendered. Having insurance is not a substitute for payment. Many companies have fixed allowances or percentages based on your contract with them not with our office. It is your responsibility to pay in advance for the deductible, coinsurance, or any other balances not paid for by your insurance. We will assist you in receiving reimbursement as much as possible, but you are responsible for your bill. **Initials** _____

FINANCIAL RESPONSIBILITY

By signing this statement you agree to be financially responsible for all charges not covered by my insurance.
Initials _____

ORDER AGREEMENT

I have reviewed and accepted the enclosed order which will be placed when a deposit of half the total is made. The balance needs to be paid in full at delivery. No checks will be accepted at the time of delivery. If glasses or contacts are not picked up 90 days after notification that they are ready, I understand the materials will be put back to stock and my deposit will be forfeited. **Initials**_____

WARRANTY COVERAGE

Any ophthalmic materials, purchased by _____ from Lovato Family Optometric Center, Inc. will have a 6 months warranty against manufacturer defects. As a supplier, Dr. Victoria A. Lovato honors all warranties expressed and implied under applicable State law. She will not charge the patient or the Medicare program for the repair or replacement of Medicare covered items or for services covered under warranty. This standard applies to all purchased and rented items, including capped rental items, as described in Sec. 414.229 of this subchapter. Dr. Victoria A. Lovato must provide, upon request, documentation that she has provided the beneficiaries with this information about Medicare covered items covered under warranty, in the form of copies of letters, logs, or signed notices. Your signature below will serve as that documentation needed.
Initials_____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize Lovato Family Optometric Center, Inc to release any medical information about me needed to determine benefits, benefits payable for related services and/or for medical related purposes to the following:

- Health Care Financing Administration and its agents
- My medical provider
- Myself via fax or email

This assignment will remain in effect until revoked in writing. A photocopy of this assignment is considered to be as valid as the original. **Initials**_____

Patient/Parent/Guardian_____Date_____

Witness_____Date_____