I understand the following responsibilities as a patient and/or guardian of the patient.

General Office Policies

No Show Policy- By Signing, I understand that if I do not give a 24 hour notice I will be charged a $35 No-Show Fee. I understand that I am to arrive 10 minutes prior to my scheduled appointment. If I do arrive after my appointment time, I will need to reschedule my appointment, and I will be charged the $35 No-Show Fee.
Minors - All children under the age of 18 need to have a Parent or Legal Guardian accompany them to all appointments.

Payment Authorization

I agree to pay ABQ Eye Care, PC for any services that the insurance DOES NOT cover at the time of service. I understand payment is due immediately after services. Any co-pays made for upgrades on eyeglasses or contact lenses will not be refunded if changes need to be made to accommodate my specific needs. I understand that it is my responsibility to pay in full for all services and materials I receive in case my insurance does not pay ABQ Eye Care, PC.

Payment is due at time of service.

HIPAA

I acknowledge that I have been given an opportunity to review and/or have received a copy of the notice of privacy practices as required by HIPAA. Signature expires one year from date signed.

Name of patient (please print clearly):_____ Date: _____

Signature of patient or guardian: _____

Relationship to Patient: _____

Authorization to Release Information to Named Individuals

Information to be Released

□ Diagnosis
□ Treatment
□ Appointments
□ Billing / Insurance
□ Pick ups (Eyeglasses, Contact Lenses, or Prescriptions)

Below are the individuals over the age of 18 who you want authorized information released to:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Authorization expires 1 year from date of signature: Date: _____

□ Patient or □ Guardian Signature: _____

Relationship to Patient: _____