PATIENT NAME: (print)_____

I authorize payment of medical benefits to the named provider—James R. Vitale, O.D. — for professional services rendered.

For services provided without a referral authorization (if needed): I acknowledge that I do not have a referral today and will be responsible for payment of services should this be denied by my health plan.

For Medicare patients: Medicare does **not cover** eyeglasses or exams for eyeglasses. There will be a charge at time of service to cover the eyeglass refraction.

I authorize the release of medical information necessary to process my claims.
I authorize the release of any insurance information and diagnosis codes to any lab used for my care.

Office policy is to give out your information only with your written approval.
Please list anyone you wish us to share your medical information with below:

PATIENT SIGNATURE:_____
DATE:_____

FINANCIAL POLICY

Copayments are due at the time of service as required by ALL insurance plans.
We do participate with most insurance plans, but not all. We cannot be sure until we see your insurance card. If you require a referral for medical visits, it is your responsibility to obtain the referral.

Our office accepts cash, checks, VISA/MASTERCARD, and DISCOVER as payment.
We will charge additional fees for all returned checks.

We reserve the right to charge patients $50 each time they do not show for their scheduled appointment or cancel an appointment with less than a 24 hour notice.