PRIVACY NOTICE

I have received the Gainesville Eye Physicians Privacy Standards
Notice of Health Information Practice.

PATIENT FINANCIAL POLICY

Co-pays, co-insurance, deductibles and non-covered services are due at the time service. A $10 charge will be added to any balance if not paid at the time of service.

CANCELLATION POLICY

A twenty-four hour notice is required for appointment cancellations. A $40 fee may be charged to the account if not canceled within this time frame or if you do not show for your appointment.

ASSIGNMENT OF BENEFITS

I hereby authorize the release of my medical or other information necessary to process this or any other related insurance claim.

I hereby authorize the release of information to other physicians or laboratories rendering services.

I have been advised that there is a possibility that some services may be denied as "not medically necessary" or non-covered services. A Refraction is a non-covered service by your Insurance Company. I acknowledge and accept liability for full payment for the present and future services, regardless of my insurance carrier's payment.

______________________________	____________________
Signature (Guardian – if minor)	Date
______________________________	____________________
Printed Name	If minor, Relationship