# Osceola Optique

## Financial Responsibility

**Please Initial All 4 Statements**

_____I agree to provide my insurance information to Osceola Optique/Dr. Jewell Chang. I acknowledge full financial responsibility for services rendered and authorize transfer of unpaid balance to me. This includes co-pays, deductibles, co-insurance and/or termination of coverage. Payment is due at the time of service. We will file your insurance as a courtesy to you. Patients are responsible for informing our office of any changes in your insurance coverage. If you neglect to update your insurance information you will be financially responsible for the full balance.

## Patient Privacy Practices

_____Osceola Optique/Dr. Jewell Chang are committed to ensuring that your protected health information (PHI) remains confidential. Your paper and electronic medical records are safeguarded and released only with your consent. This includes your insurance carrier, pharmacy and other medical professionals directly involved with your care. I am aware that a copy of the privacy practices is available upon request.

If you would like us to release your PHI to any family members please list them below.

| Name: | Phone Number: | Relationship: |
|---|---|---|
| 1. | | |
| 2. | | |

## Canceling Appointments

_____Please be advised a **$50.00 MISSED APPOINTMENT FEE** will be charged for any appointments that are not canceled **48 hours** in advance.

_____ Due to the custom and medical natures of eyewear, **ALL SALES ARE FINAL**. This includes eyeglasses, sunglsses, contact lenses and OTC products.

**I HAVE READ, UNDERSTAND AND ACCEPT THE 'FINANCIAL RESPONSIBILITY', 'HIPPA & RELEASE OF MEDICAL INFORMATION POLICY' AND 'CANCELATION POLICY.'**

| _____ | _____ | ____/_____/____ |
|---|---|---|
| **Print Name** | **Patient/Guardian Signature** | **Date** |