Denville Family Eyecare
5 East Main Street Suite 7
Denville, NJ 07834
973-983-0400

We are pleased you have chosen our office to assist you with your routine and medical ocular needs. Our staff is committed to providing you, your family and friends, with comprehensive care in a professional and supportive environment.

In order to establish an optical relationship with our patients and to avoid misunderstanding; we ask that you read and sign this form. Payment in full is required for all services at the time they are provided. **Custom materials are being ordered for you and therefore cannot be returned after the order is placed**. All insurance must be provided to the office at the time services are rendered. If provided after the date of service, patient will be given an itemized receipt to self submit. Those patients using a vision plan or medical insurance, all co-pays are required at time of service. If claim is denied, due to false insurance being received or if payment is applied to deductible, co-insurance, or non-covered services, or for any other reason, you are responsible for the balance billed to you.

Contact lens fit/evaluation **must** occur either on the same day as your routine eyeglass exam or within 3 months of that first exam so as not to incur an addition fee.

Any change in prescriptions must be performed within 60 days of original sale or the patient will be responsible for the new lenses in full.

WARRANTY COVERAGE- LENS &/OR FRAME WARRANTY WILL BE TO LIMITED ONE REPLACEMENT WITHIN THE YEAR – USING ORIGINAL DATE. FURTHER REMAKES – WILL BE AT 30% DISCOUNT OF USUAL & CUSTOMARY CHARGE.

Progressive lens – non-adapt- If you can not adapt to progressive lenses the office agrees to redo to either a lined bifocal or single vision lens for no additional charge, within the 60 day period.

NO REFUNDS WILL BE ISSUED --- ONLY STORE CREDIT TO BE USED ON MATERIALS ONLY
A RESTOCKING FEE FOR MATERIALS MAY APPLY

Monthly statements will be sent to you for payment of any balance due after your insurance carrier has processed the claims. If you do not respond to our monthly statements, a final statement will advise you that your account will be sent to collections. At that point, you agree to pay $50 or 20%, as a collection fee, whichever is greater, in addition to your balance. Once your account is placed in collections, continuation of care will be provided to you for emergency purposes only unless payment is made in full to the office.

A return check charge of $35 will be charged for checks returned unpaid by your bank.

A restocking fee of $25 will be accessed if spectacle and / or contact lenses have been returned due to non pick up within 30 days of first notification.

Our practice is dedicated to maintaining the privacy of your individual health information. We are required by law to maintain the confidentiality of this health information under the Health Insurance Portability and Accountability (HIPAA). We cannot release or discuss personal medical information with any one unless you have given us written permission to do so.

Your signature below signifies that you have read and understand our office policy. Under this agreement you authorize insurance payments to be made directly to the practice.

Patient/Guardian Signature _____Date _____

Patient Printed Name _____