Insurance Disclaimer:
"A quote of benefits and/or authorization does not guarantee payment or verify eligibility. Payment of benefits are subject to all terms, conditions, limitations, and exclusions of the member's contract at time of service."

Beneficiary Agreement:
I understand that my health insurance company may deny payment for the services identified above, for the reasons stated. If my health insurance company denies payment, I agree to be personally and fully responsible for payment. I also understand that if my health insurance company does make payment for services, I will be responsible for any co-payment, deductible, or coinsurance that applies.

Refraction Notice:
An important part of your eye exam today is the refraction which determines if you can be helped in any way by a new glasses prescription. It is also how we determine the best possible visual acuity and function of your eye, which is essential medical information for us to have as we assess your eyes and rule out problems. Medicare and most insurance companies DO NOT cover the charge for a refraction. Our office policy is to charge $25.00 for this procedure in addition to the office visit co-pay and/or deductible. Payment is due at the time services are rendered. Please inform the technician if you decline a refraction today. It is important to understand that if you decline, we may not be able to determine the cause for your decrease in vision.

ACKNOWLEDGEMENT OF PRIVACY POLICY AND PRACTICES

I understand that in an attempt to protect the privacy of my identifiable health information, *Del Family Eyecare of Homestead, (DFE)* has established a *Privacy Policy* and guidelines for *Privacy Practices* within their office. This information details the use and/or disclosure of information contained in my personal medical/ optometric records kept for the purposes of diagnosis, treatment, payment and health care operations. In accordance with HIPAA Regulations, a copy of the *DFE Privacy Policy & Practices* has been made available to me while in the office today. Should I choose to have a personal copy; one will be given to me at no charge.

I have read, understand and acknowledge the Privacy Policy and Practices of DFE, as well as the insurance disclaimer, Liability for payment, and refraction notice.

_____
Print name

_____ _____
Signature Today's Date