Friedrich
Eye Associates, PLLC

FINANCIAL AGREEMENT

The financial policy has been fully explained to me and I acknowledge full responsibility for all charges incurred, including any additional charges incurred during the collection of this account, if my insurance later determines my services to be non-covered or not a benefit.

Signature: X_____ Date: _____

PRIVACY POLICY

I understand that HIPPA has implemented procedures that require specific authorization for the release of my information. I agree to the following statements and understand that I can revoke these at any time by informing the Privacy Office in writing:

***Home Telephone:** We may leave a message with a callback number or appointment reminder on voicemail.

***Written Communication:** We may mail postcards to your home address or send you an email.

Signature: X_____ Date: _____

INSURANCE AUTHORZATION

I authorize and request that payments under my medical insurance plan(s) be made directly to pay the provider for any services furnished to me. I also authorize the provider to release any information needed for payment of claims. I further permit copies of this authorization to be used in place of the original.

Signature: X_____ Date: _____

CANCELLATION/NO SHOW POLICY

Unfortunately, due to the increasing number or no shows and cancellations, please be aware of the following policies:

Each no-show will be charged a $50.00 fee.

If you cancel for any reason, you must give at least 24-hour notice, or you will be charged $50.00.

2 "no-show" or 3 cancellation appointments within a rolling 12-month period may result in possible dismissal from this practice.

Signature: X_____ Date: _____