Orange Park Eye Center

Drs. Abshire, Hoffman, Larson, Bowman, Reed, Hodges & Hodges

Optometric Physicians

905 Park Ave. Ste. 100
Orange Park, Florida 32073
904-264-1206
904-264-3685

784 Blanding Blvd. Ste. 100
Orange Park, Florida 32065
904-272-3937
904-272-3436

Financial Policy

In order to control the cost of billing, we ask that the patient's portion of fees assessed be paid at the time at which services are rendered. We would rather control billing costs than be forced to raise our fees. All professional services and materials are charged to the patient. No refunds will be given on glasses or contact lenses. The undersigned will ultimately be responsible for any bills incurred in this practice- regardless of insurance. Accounts ninety (90) days old are subject to collection fees. There will be a service charge added to any returned checks.

_____ (Initials)

Provider claims

I, the undersigned, authorize any holder of medical information about me to release- to my insurance company- any information needed to determine benefits payable for related services. Payment from my insurance company is to be paid directly to Drs. Abshire, Hoffman, Hoffman, Bowman, Hodges, Hodges, and Poole. I understand that the insurance that I provide will be billed as my primary insurance and that any secondary insurance information should be given a the time services are rendered. I understand that all benefits quoted to me are not a guarantee of payment by my insurance company, and that final determination can only be made when the claim is processed.

_____(Initials)

Privacy Policy

I acknowledge that I have received and/or been offered a copy of Drs. Abshire, Hoffman, Hoffman, Bowman, Hodges, Hodges, and Poole Notice of Privacy Practices. I authorize the Orange Park Eye Center to leave a detailed message to confirm my eye appointment.

_____(Initials)

Notice of Cancellation/No Show Fees

I understand that the Orange Park Eye Center charges a $50.00 fee for failure to give a 24-hour advance notice to reschedule or cancel an appointment.

_____(Initials)

Authorization to Release Medical Information

I, the undersigned, authorize _____ to have access to any of my records obtained at the Orange Park Eye Center.

Authorization to Make Decisions Regarding Legal Minor

I, the undersigned, authorize _____ to make decisions regarding the minor in my legal guardianship in my stead.

_____

Patient Name (Please Print)

_____

Patient Signature

_____/_____/20_____

Today's Date