

Orange Park Eye Center

Drs. Abshire, Hoffman, Hoffman, Bowman, Hodges, Hodges, and McClintic.

905 Park Avenue, Suite 100
Orange Park, Florida 32073
(904) 264-1206

784 Blanding Boulevard, Suite 100
Orange Park, Florida 32065
(904) 272-3937

Financial Policy

In order to control the cost of billing instead of increasing our fees, we ask that the patient's portion of fees assessed be paid at the time at which services are rendered. All professional services and materials are charged to the patient. No refunds will be given on eyeglasses 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.

_____ Initial

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 Orange Park Eye Center. I understand that the insurance that I provide will be billed as my primary insurance and that any primary, secondary or other insurance information should be given before 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 once the claim is processed.

_____ Initial

Privacy Policy

I acknowledge that I have received and/or been offered a copy of Orange Park Eye Center's Notice of Privacy Practices. I authorize Orange Park Eye Center to leave a detailed phone or text message regarding information needed, appointment conformation, eye wear notification, or other notifications.

_____ Initial

Notice of Cancellation/No Show Fees

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

_____ Initial

Authorization to Make Decisions Regarding a Legal Minor

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

_____ Initial

Patient Name (Print) _____

Patient or Legal Guardian Signature _____ Date ____/____/20____