Vision Source – Shadow Creek **FINANCIAL POLICY &** **713-436-7544**
Dr. Dipak R. Kalani **PRIVACY POLICY** **visionsource-shadowcreek.com**
Dr. Linda S Haidar

Payment of all services and materials are payable at the time of your visit.

Co-pays are required at the time of service. You will be billed for deductibles or any additional co-pay as indicated by your insurance company at the time of their payment. Please be advised that the contract between you and your insurance company is a separate contract from that between you and our clinic. ***It is your responsibility to be knowledgeable of your own insurance coverage/benefits/eligibility and to alert our staff should your coverage change or be discontinued.***

All Glasses / Contact Lens Orders – Full payment is required before order can be placed and processed.

- **Contact Lenses** – Once purchased, open boxes cannot be returned for credit or exchanges.
  > There will be a $65 re-fitting fee if any changes need to be made after 30 days.

> Glasses Purchased from OUR clinic - within 30 days of purchase, 1 time Verification and Reevaluation is performed at no charge.

>>> Glasses NOT purchused from OUR clinic - $65 Verification and Reevaluation Fee applies each time patient returns with issues with those glasses.

All Sales are Final as each Eyeglass order or Contact Lens order is Specific to each patient.

We are NOT responsible for any materials left in our office over 60 days. NO refunds, credits will be given for any products left at our office past 60 days.

Returned checks: A fee of $35 will be billed to your account for any returned checks unpaid.

Appointment NO SHOW/CANCELLATION POLICY-

A patient who fails to show or cancels an appointment and has not notified our office **within 24hrs** will be charged **a $25 fee.**

These fees will be charged to the patient, not the insurance company, and is due at time of the patients next office visit or billed as a balance due.

Effective Date: By signing this financial policy, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

The **Health Insurance Portability & Accountability Act of 1996 ("HIPAA")** is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. As required by "HIPAA", we have prepared a **"Notice of Privacy Practices Policy"**. This explains how we are required to maintain the privacy of your health information and how we may use and disclose your health information. A copy of this policy is available to you at your request and on our website.

Communication is the key to good relationships. Please feel free to ask any questions you have and we will be happy to help you.

The Staff and Doctors of Vision Source – Shadow Creek

I authorize the release of any information necessary to process insurance claims.
I am aware of the financial policy of Vision Source – Shadow Creek.

Patient's Name: _____
(Please print clearly) Last Name First Name

Authorized Signature: _____ Date: _____