Office Policies

We are committed to offering the highest quality eye care and service possible. Please review our office policies and sign below.

Examinations and Fees

Professional fees and copayments are due at the time services are rendered. Prescriptions and exam records will not be released if fees have not been paid. Professional fees are non-refundable.

Insurance

It is the patient's responsibility to disclose and confirm any type of vision plan or medical insurance coverage **before** exams, services and products are rendered. If a vision plan or medical insurance coverage is determined after services or product ordering have been initiated, we cannot submit an insurance claim on behalf of the patient. In order to utilize an insurance plan, the patient must contact their insurance company for any potential reimbursement on their own behalf. We will gladly provide any itemized bills, diagnosis codes, and procedure codes required.

Insurance Disclaimer: Verification of eligibility and/or benefit information is not a guarantee of payment. Benefits will be determined once a claim is processed and will be based upon—among other things—member's eligibility, any claims received during the interim period and the terms of the member's certificate of coverage applicable on the date services were rendered.

Contact Lens Policies

Contact lenses are medical devices that require a comprehensive vision and eye health evaluation before they are prescribed. A final contact lens prescription is released only when all necessary follow up visits are completed to ensure that the contacts lenses fitted are appropriate for your eyes and visual needs.

If you are unable to adapt to your contact lenses, you have within 90 days to return for a refit with a new lens, and will be charged the difference. We can offer credit for unopened boxes that are in resalable condition, but do not offer refunds. It is the contact lens company's policy that any pen markings or small damages on a box will make it non-returnable. If you receive a damaged contact lens box through the mail, please notify us immediately because these contact lens companies will deny a return if you we try to return it later.

Eye wear or Contact Lens Orders

Payment in full is required when an order for glasses or contacts is placed.

All sales are final. We strive for prompt service; therefore, your order is placed with our laboratories and frame distributors immediately. Since eye wear is completely customized for each patient, we are unable to reverse or halt your order once production has been initiated. We do not offer cash refunds.

We accept cash, check, American Express, Discover, Mastercard, and Visa.

Any check returned for insufficient funds will incur a $30 service fee.

We take pride in our products. If your prescription has changed, you have within 60 days of your order placement, to have a one-time prescription change.

If you are requesting a frame style change, we will be unable to use your existing lenses in a new frame, and you may be charged an additional fee for new lenses.

Most, but not all, frames have a one-year warranty. All lenses with anti-reflection have a 2-year warranty. All other lenses have a 1-year warranty.

Out-of-office Orders

We are not responsible for the accuracy or quality of materials produced outside of our office. If you choose to have glasses made outside of our office, we recommend seeking a dispenser who will agree to waive any additional fees in the event your prescription has changed.

Our staff is happy to repair or adjust any frames purchased from this office. Fees will be applied to any parts or services for products purchased ***outside*** of our office.

Pupil distances (PDs) are **NOT** a standard part of your glasses prescription, nor considered standard testing during an examination, according to New York State law. These measurements are obtained by licensed optometrists or opticians at the time of service.

I have read and understand the office policies, and acknowledge that I have been given the opportunity to receive a copy of these policies. I also understand that I may request a copy at any time.

Patient/Guardian Signature___________________________________ Date_______________________

Print Patient's Name____

Print Guardian Name____

Witness Signature and Name__________________________________ Date_______________________