Privacy Notice Acknowledgment

As required by Federal Law, Westrum Optometry has made its Privacy Notice available to me. The notice summarizes ways my Protected Health information may be used and disclosed.

X _____ _____

Signature of Patient/Guardian/Representative Date Signed

X _____

Relationship of Guardian/Representative to Patient

Insurance Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Westrum Optometry, Dr. Westrum, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.
Dr. Westrum, Westrum Optometry may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

X _____ _____

Signature of Patient/Guardian/Representative Date Signed

_____ _____

Please Print name of Patient, Guardian or Personal Representative Relationship to Patient

Westrum Optometry Policies and Warranties

Frame Warranty Policy
*Each frame has a one year breakage warranty, from normal wear and tear or manufacturers defect. There are no warranties on lost frames.

X _____

Initials

Contact Lens Policy
*Contact lens fittings are $40.00, and includes follow up appointments up to one month after initial exam. Contact lens prescriptions are valid for one year after initial exam. Unopened, unmarked and undamaged boxes of contacts can be returned for credit up to six months after purchase. Shipping costs for contacts to be shipped to your home are $5.00. Shipping costs are waived when purchasing a year supply.

X _____

initials