NOBLE
EYES

NOTICE OF PATIENT PRIVACY RIGHTS, PROTECTION, AND RESPONSIBILITIES

SERVICES PROVIDED WITHOUT REFERRAL AUTHORIZATION

As a member of a vision care program, I acknowledge that for today's visit, I will assume full financial responsibility for services rendered to me if my vision insurance carrier denies or does not cover my claim for these services.

MEDICAL NECESSITY

If my insurance determines that a medical service and/or material is not covered, I acknowledge that I have been notified and will assume full responsibility for the service(s) and/or material as outlined below.

COPAYMENTS

I understand that I am responsible for paying all co-payments at the time of service, prior to leaving. Co-payments cannot be waived at any time by the provider of service or Noble Eyes.

DEDUCTIBLES

If my insurance determines that I have not met my deductible, I understand that I will be fully responsible for payment in a timely manner, no later than 30 days after being notified by insurance and/or provider. Yearly deductibles cannot be waived at any time by Noble Eyes.

PATIENT ACKNOWLEDGEMENT AND GUARANTEES

I understand I am responsible for all professional fees at the time of service, and all materials must be paid in full before ordering. If I use my own frame, I accept the risk of breakage and release Noble Eyes and my insurance from liability.

All products are custom-made and non-refundable. If I cancel or return a product after it's made, a $70 restocking fee applies. If not picked up within 60 days, materials will be returned and fees forfeited.

Noble Eyes offers a satisfaction guarantee on premium single vision and progressive lenses. If I have trouble adapting, lenses will be remade once in the same frame. If still unsatisfied, they'll be replaced with lined bifocals or single vision lenses—no refunds.

HIPAA PRIVACY RIGHTS

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), which I have been provided a copy of, I have certain rights to privacy regarding my protected health information. This information may be used to conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in my care, obtain payment from third-party payers, and conduct normal healthcare operations such as quality assessments and physician certifications.

AGREEMENT

I, the undersigned, acknowledge that I have read and understood the terms of this agreement, including my responsibilities regarding payment and the no-refund policy for custom-made products. By signing below, I agree to the terms and conditions outlined above.

Date: _____

Signature: _____