**Signature on-file**

**Patient Financial Policy**

**Patient Guidelines and Expectations**

**Eyeglass/Contact Lens Prescription Policy**

The above policies are available for viewing in person or on our website at [www.lgeyecare.com](http://www.lgeyecare.com)

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ understand and agree that I am responsible for the payment of any and all charges incurred as a result of this or any subsequent office visit(s) for myself and any family members I am financially responsible for. I also understand and agree to accept responsibility for payment for all insurance deductibles and any incurred expenses not covered by my insurance carrier.

Los Gatos Eye Care will provide you with a copy of your eyeglass and/or contact lens prescription at the conclusion of your eye exam (provided the contact lens prescription is finalized). I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ give permission to Los Gatos Eye Care to email or fax me a copy of my valid prescription in the future if I request it.

My signature below confirms that I have read and understand the Patient Financial Policy, Patient Guidelines and Expectations and Eyeglass/Contact Lens prescription policy.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient / Legal Guardian Signature Relationship to Patient

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date