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I acknowledge that I received a copy of PERFECT OPTICAL EYECARE CENTER Notice of Privacy Practices.

Patient Name _____

Signature of Patient, Parent, or Guardian _____ Date _____

Are we Filing Vision or Health Insurance? YES NO Insurance is filed as a courtesy. Patient retains all financial responsibility for products or services rendered. *If YES, please read and sign the statement below.*

I authorize the physician to release any information required to process this claim. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for non-covered services, including co-pays and non-payment by insurance company.

Signature of Patient, Parent, or Guardian _____ Date _____

Please Fill out completely and present any insurance cards to the front desk.

Medical Insurance: Insured Name _____ Plan Name _____ Contract Number _____
Insured Relationship _____ Address _____ Birth date _____

Vision Insurance: Insured Name _____ Plan Name _____ Contract Number _____
Insured Relationship _____ Address _____ Birth date _____

Would You like a Contact Lens Fitting Today? YES NO *If YES, please read and sign below.*

Contact Lens Fitting Agreement

Contact lenses are an exciting option to correct vision. There are, however, inherent risks with contact lens use, and particularly their abuse. Always replace lenses regularly as instructed by the doctor. Never sleep in a contact lens that has not been fit for such use. Never share your contact lenses with anyone, and never use contacts that have not been fit for you. Keep your lenses clean as instructed by the doctor and always replace dirty or damaged lenses. Neglect of these practices will lead to infection, inflammation, or other problems with your vision or eye health. If your eyes become red, irritated or sore do not wear your contacts. If these symptoms persist come in for an evaluation immediately. If it is after hours please call **289-1951**.

New patients or those who are fit in a different contact lens **must have a follow-up visit**, verifying the safety and effectiveness of the contact lenses, before the contact lens prescription will be finalized. Healthy eye contact lens follow-up visits are included for the first 60 days after the date of the exam. **If you have not had your contact lens prescription finalized within these 60 days, each follow-up visit will include a \$25.00 fee. If 4 months have expired since the date of the initial exam, no follow-up visits will be given to finalize or change the prescription.** Contact lens prescriptions generally expire 1 year after the date of the initial exam. Examination and fitting fee cover professional services only, and do not include the cost of any materials or supplies. Most patients successfully wear contact lenses, but a successful fit and wearing experience cannot be guaranteed. No Professional fees will be refunded.

Signature of Patient, Parent, or Guardian _____ Date _____