Patient Responsibility Statement

I have insurance coverage, and authorize direct payment from my insurance carrier to Consumer Optical Co. Inc.
*You are responsible for knowing your coverage benefits at the time of service. If there are any changes to your insurance, please let us know immediately so we can submit your claim properly.

Optical Insurance Plan_____

Medical Insurance Plan_____

(Please present insurance card(s) and/or forms to receptionist at arrival)

I do not have insurance coverage and understand that I am responsible for payment of all charges.

I understand that if my eligibility cannot be verified or my coverage has been terminated before my date of service, I will be financially responsible for payment of all charges incurred for my services received at Consumer Optical.

Patient:_____Date:_____

Parent/Guardian(if minor):_____ Date:_____

We also offer Care Credit® no interest monthly payment finance as an alternative to credit cards (application and online approval available in minutes at our office).

Cancellation Policy
Effective 8/15/2023

A notice of 24 hours prior to appointment is required for cancellation. If appointment is cancelled with less than 24 hours notice, a fee of $25.00 is required prior to rescheduling of appointment.

Patient:_____Date:_____

Parent/Guardian(if minor):_____ Date:_____