The Eyewear Gallery
at Reston Town Center
Optometrist

Last Name: _____ First Name: _____

Cell Phone: _____ Email: _____

Home Phone: _____ Last 4 digits of SSN: _____ Date of Birth: _____

Whom may we thank for referring you?_____

***We use text and e-mail for appointment confirmations and office communications. WE NEVER SHARE YOUR INFORMATION

Note: In compliance with the HIPAA Privacy Rules, all patient information is kept strictly confidential. Your information is NEVER shared.

In addition to your regular eye examination, there is a contact lens fitting fee associated with contact lenses. **Vision plans only cover yearly eye wellness exams, along with sometimes contributing to your spectacle or contact lens purchase. Vision plans do not cover medical eye care (diagnosis, management or treatment of eye health issues).** Medical insurance must be for medical eye care.

I understand that I am responsible for any co-payments that are linked to my examination and/or glasses/contact lens benefit through my vision insurance. *** Failure of payment in full after 30 days, will result in legal action which includes your account being sent to an attorney or collection agency where additional collection of legal fees will be applied up to 33 and 1/3%

I also understand that medical testing may be necessary to be scheduled for a later date and will be billed to my medical insurance (e.g. diagnostic imaging and testing for ocular diseases such as glaucoma, cataracts, etc). I understand that I am responsible for any co-pays, co-insurance and/or yearly deductibles that are linked to my medical insurance. I also understand there may be a charge for pupillary measurement and/or evaluation and adjustment of eyewear purchased outside this office.

I authorize payment of benefits to be made directly to Dr. Dawn Gammon. I understand and agree that, regardless of my insurance status, (e.g. deductible not met, referral not provided, etc) I am ultimately responsible for the balance of my account for any services rendered.

All insurance information is the responsibility of the patient and must be given PRIOR to the exam date or an itemized receipt will be provided for the patient to submit. We cannot back bill your claims.

I acknowledge that I have read & understood the Notice of Privacy Practices of Dr. Dawn Gammon

Signature: _____Signature of Parent/Guardian: _____Date: _____