10120 S. Eastern Ave., Suite 165
Henderson NV 89052
Phone: 702-456-9585 Fax: 702-456-0011
www.EnvisionNv.com

Patient's First and Last Name ______________________________________DOB _____________

Legal Guardian First and Last Name ____

AUTHORIZATION TO PAY BENEFITS TO CLINIC I hereby assign payment directly to Envision Eyecare for medical and vision benefits, if any, otherwise payable to me for service provided at the clinic (not to exceed my indebtedness to the clinic). I understand that I am financially responsible for charges not covered by my insurance.

RETURN POLICY Prescription eyewear, because they are a custom-made product, cannot be returned, changed, or refunded after 24 hours of order placement. All frames and coatings are warranted against workmanship defects for 1 year from the date of purchase. Obvious abuse is not considered a defect. Lenses that have a premium antireflective coating will be replaced for scratches 1 time, at no charge, within 1 year of the original order. Our doctor change and non-adapt policy allows for a 1 time exchange, at no charge, for a different lens type, frame, or prescription, of equal or lesser value, within 30 days of original order. There is not a frame or lens warranty when a patient's own frame is used. There is a higher possibility of frame breakage due to the quality or age of the frame, the lab processes, and the desert environment.

AUTHORIZATION TO RELEASE INFORMATION I hereby authorize Envision Eyecare to release any information acquired in the course of my examination or treatment to another physician and/or my insurance company.

I designate the following person(s) to access my medical and financial records:

Name _____________________________Relationship_______________Phone_______________

ACKNOWLEDGEMENT I have read and understand the above financial policies, return policy, office policies, and benefit authorization and agree to all provisions outlined herein.

Signature____Date________________

HIPPA ACKNOWLEDGEMENT I acknowledge that I have received and reviewed a copy of the Notice of Privacy Practices. I have also been given an opportunity to request restriction on the use and disclosure of my protected health information.

Signature____Date________________

PATIENT NON-DISCRIMINATION POLICY

Envision Eyecare celebrates the diversity of our clinic community. Our clinic is committed to treating all patients and prohibits discrimination against people on the basis of race, color, creed, religion, national origin, age, ability, sex, gender identity or expression, affectional or sexual orientation, marital statuses (including domestic partnerships and civil unions) or any other basis protected by federal, state, or local law.

If you experience any discrimination that you feel is related to your identity-status, please notify
Erika Duggan, optometrist
702-456-9585 or eyedrs@envisionnv.com