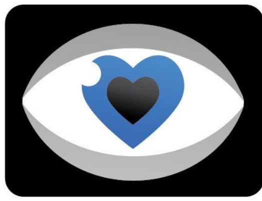

EYECARE ROCKWALL

Holly Fisher Britt O.D.   Thuy Lieu O.D.   Laura Wiese O.D.   Ross Moulder O.D.

Returned Checks

All returned checks will be assessed a $35.00 fee. All returned checks not paid in full within 15 days will be filed with the proper authorities. Thank you for your understanding concerning our financial policy. Please let us know if you have questions or concerns.

_________ Initial

Return Purchase Policy

Glasses are considered a custom optical device, and can accommodate only the patient for which they were created. Eyecare Rockwall will assure that your glasses are made according to your doctor's prescription and are free of defects after lab processing. However, due to the custom nature of an optical purchase, there will be NO refunds on such lenses. Special conditions may apply.

If you plan to use your own previously worn frame, Eyecare Rockwall cannot be responsible for any loss of breakage of your frame during shipping, or within the lens fabrication process. In the event of loss and / or breakage you agree to be personally responsible for any expenses associated with loss and / or breakage.

If contact lens products are purchased and a return is requested or the product is not picked up within 45 days, a restocking fee of $25.00 will be billed to you.

________ Initial

Pupil Dilation Retinal Examination

Dilating drops are used to dilate or enlarge the pupil of the eye to allow the optometrist to get a better view of the inside of your eye. Dilating drops frequently blur vision for a length of time which varies from person to person and may make bright lights bothersome. It is not possible for your optometrist to predict how much your vision will be affected. Because of this, driving and getting around immediately after an examination may be difficult (such as falls, etc) and one should make arrangements to not drive and to have someone assist in getting around. Adverse reaction, such as acute angle-closure glaucoma, may be triggered from the dilating drops. This is extremely rare and treatable with immediate medical attention.

____   ________________________

Signature of patient or responsible party   Date

Acknowledgment of Receipt of Notice of Privacy Practices

I have acknowledged receipt of a copy of this office's Notice of Privacy Practices.

(please see laminated form)

By signing below, I affirm that I have read and understood the policies provided

____   ________________________

Signature of patient or responsible party   *Date*

If applicable,

Contact Lens Service Agreement

By signing below, I acknowledge that I have read and agree to the Contact Lens Service Agreement.

(please see laminated form)

____   ________________________

Signature of patient or responsible party   *Date*