STATEMENT OF FINANCIAL POLICIES

WELCOME TO *VISION SOURCE*

Whom may we thank for referring you?_____

1. PAYMENT IS DUE WHEN SERVICES ARE RENDERED.

2. **WE ACCEPT CASH, CREDIT CARDS, AND DEBIT CARDS AS PAYMENT. WE DO NOT ACCEPT PERSONAL OR BUSINESS CHECKS.**

3. **FULL PAYMENT IS DUE WHEN MATERIALS ARE ORDERED.** ONCE MATERIALS ARE ORDERED THERE WILL BE NO REFUNDS OR EXCHANGES.

4. I UNDERSTAND THAT I AM RESPONSIBLE FOR PAYMENT OF MY ACCOUNT, EVENTHOUGH I MAY BE USING INSURANCE. IN THE EVENT MY INSURANCE COMPANY DOES NOT PAY THE FULL AMOUNT DUE WITHIN 90 DAYS, I AGREE TO PAY THE OUTSTANDING BALANCE UPON NOTIFICATION BY DR. MORRIS.

5. THE DOCTOR, AT HIS DISCRETION, MAY PLACE AN UNPAID ACCOUNT WITH AN ATTORNEY FOR COLLECTION. IN THE EVENT MY ACCOUNT IS REFERRED TO AN ATTORNEY FOR COLLECTION, I OR MY PARENT (IF PATIENT IS A MINOR) AGREE TO PAY AN ATTORNEY'S FEE, COURT COSTS, AND ANY OTHER REASONABLE COSTS OF COLLECTION.

6. THIS OFFICE WILL NOT BE HELD LIABLE FOR PATIENT'S OWN MATERIAL(S) LEFT AFTER 30 DAYS. DEPOSITS ARE NOT REFUNDABLE.

I HAVE READ, UNDERSTAND, AND AGREE TO THE TERMS AND CONDITIONS ABOVE.

DATE_____PATIENT NAME_____
SIGNATURE_____WITNESS_____

PERSON RESPONSIBLE FOR THIS ACCOUNT (COMPLETE THE SECTION BELOW IF THE PERSON RESPONSIBLE FOR THIS ACCOUNT IS OTHER THAN THE PATIENT).
NAME_____RELATIONSHIP_____
PHONE_____SIGNATURE_____
ADDRESS (IF DIFFERENT FROM PATIENT)_____
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