OFFICE AGREEMENT

- Patients have 90 (NINETY) DAYS from the date of the exam to return with a problem for a prescription check at no charge regardless of when or where spectacles or contact lenses are purchased.
- If a patient returns after 90 (NINETY) DAYS from the date of the exam for a prescription check, it is considered a new exam. A typical exam fee of $90.00 will be charged if the patient does to have any other insurance coverage for the exam.
- Once a purchase is initiated at our office, patients have 1 (ONE) BUSINESS DAY to cancel the purchase for a **full refund**.
- If the purchase is not cancelled within 1 (ONE) BUSINESS DAY or if at any point the patient wants to return frames, lenses, and/or contact lenses, the patient is responsible for paying the lab costs for the generated lenses and/or a 10% restocking fee (based on retail value) for all returned frames and contact lens boxes.
- All returned/canceled items that used insurance benefits in the initial purchase do not guarantee a reinstatement of insurance benefits upon return. Each individual insurance company, not our office, solely determines insurance benefits.
- Opened contact lens boxes CANNOT BE RETURNED.
- Any unpaid balances will be transferred to a debt collection agency for payment recoupment 30 (THIRTY) DAYS after a balance due letter is sent.
- All materials and quotes are provided based on your current unused insurance benefits. Any use of your insurance after the quote has been provided renders the quote invalid.

ADVANCED BENEFICIARY NOTICE / PATIENT INSURANCE AGREEMENT

I certify that the information given by me in applying for insurance is true and correct. I hereby authorize and direct payment of my vision and/or medical benefits to Roanoke Vision Associates PLLC DBA Vision Source Trophy Club. ALTHOUGH EVERY EFFORT IS MADE TO CORRECTLY QUOTE ME WHAT MY INSURANCE BENEFITS COVER, FINAL DETERMINATION OF PAYMENT IS MADE WHEN MY INSURANCE CLAIM IS SUBMITTED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY NON-COVERED SERVICES, CO-PAYMENTS, AND DEDUCTIBLES, IN THE EVENT THAT MY VISION/HEALTH PLAN DETERMINES A SERVICE TO BE "NOT-COVERED" AND DENIES PAYMENT FOR ANY REASON, I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR THE COMPLETE CHARGE. I authorize the release of any medical or other information necessary to process my insurance claims. I understand that my signature on this form will serve as a permanent signature on file and will be used for accepting assignment purposes only for those plans which Vision Source Trophy Club, Dr. Kelvin Lam O.D or participating providers

-I have read, understood and agree to abide by each aspects of the Advance Beneficiary Notice/Patient Insurance Agreement.
-I have read and understood and agree to abide by each aspect of the office agreement