Hoover Vision Center
Office Policies

Dr. Robin L. Marbourg **Dr. Abnous A. Samford**

Thank you for choosing our office to provide for your eye care needs. We strive to provide our patients with quality comprehensive eye care in a timely manner. To meet our goal, we must adhere to the following office policies. Please read and initial each one and sign at the bottom showing that you have read and understand our policies.

(Initial)_____**BROKEN APPOINTMENTS** – A 24 HOUR NOTICE is required to cancel or change your eye exam appointment. Three (3) broken appointments within a twelve (12) month period will result in "Day of Call Only" status. This means that going forward, you will no longer be given an appointment slot in advance. You can call on the day you desire service and ask to be worked into the existing schedule. We will do our best to accommodate that request but will do so without obligation if our schedule is already full. Consideration will be given to any ocular emergency issues/conditions.

Note: Exceptions to this policy will be determined on an individual basis, according to circumstance. We understand that illness or other unexpected emergencies arise that make it necessary to cancel an appointment with less than a 24 hour notice. Please be courteous and contact our office as soon as possible, so that we can offer that appointment to another patient in need of care.

(Initial)_____**LATE ARRIVALS** – If you arrive more than fifteen (15) minutes late for your scheduled appointment time you may be asked to reschedule. Depending on our daily schedule you may be able to be worked in. If you agree to do so, you must wait until an appointment time is available or another patient reschedules. We strive to stay on schedule and late arrivals can cause a disruption, resulting in an increase wait time for others the rest of the clinic day.

(Initial)_____**COURTESY CONFIRMATION** – Our office provides a call and/or e-mail/text method of confirmation and reminder before your scheduled appointment. Please remember this is a courtesy, and you are still responsible for keeping your scheduled appointment time. Please respond to this confirmation as soon as possible, so we can plan accordingly to meet your eye care needs.

(Initial)_____**EYE & HEALTH INSURANCE** – Please provide our office with your current eye/health insurance information before arriving for your eye exam appointment so that we may provide you with the *ESTIMATED* cost of your appointment.

(Initial)_____We file your eye/health insurance as a courtesy to you.
(Initial)_____We do not have a contract with your insurance company, only you do. We have agreed to be panel members and provide services.
(Initial)_____It is your responsibility to notify our office of any changes with your eye/health insurance carrier.
(Initial)_____**Patients are responsible for paying their copays and non-covered fees in full at time of service.**

(Initial)_____**RETURNED CHECK FEE** – There is a $30.00 returned check fee on all returned checks.

(Initial)_____**PRIVATE PAY** – Payment is due in full at the time of service

Patient/Guardian Name:_____

Signature:_____ Date:_____