SOLD BY:					FLEXSYS BY:	DATE:		DOCTOR:	
PATIENT NAME:								DOB:	
FRAME:					**NEW** **POF**	V2020		**U & C**	**OOP**
BRAND:		STYLE:			COLOR:	SIZE:			
FULL RIM		SEMI-RIMLESS			DRILLED RIMLESS	V2799	$40		
SINGLE VISION:			**DISTANCE**		**COMPUTER**	**READING**			
SV						V21XX	$130		
MY SV	SYNC III	500	750	1000	1250	V21XX + V2410	$180		
BIFOCAL:			**DISTANCE/READING**			**COMPUTER/READING**			
ST28	ROUND SEG 28					V22XX	$170		
ST35	OCCUPATIONAL BIFOCAL						$260		
TRIFOCAL:									
STT7X28						V23XX	$190		
STT8X35							$280		
PROGRESSIVE:									
MYSTYLE 2	LIFESTYLE 3	MAUI JIM				V2781	$420		
ARRAY 2							$340		
CD/ECP BKS	ID:	ZOOM	SCREEN	SPACE			$250		
MATERIAL:									
PLASTIC - $0	POLY	TRIVEX	MAUI BRILLIANT			V2784	$90		
HI-INDEX:	1.60	1.67	1.70	1.74		V2782 or V2783	$140		
ANTI-REFLECTIVE:									
EX3	RECHARGE	PREMIUM W/ VP	MAUI JIM A/R			V2750	$150		
EX3+ W/ BACKSIDE UV		EX4				V2750 + V2755	$170		
PHOTOCHROMIC: SENSITY OR TRANSITIONS									
GREY	DK GREY	FAST GREY	GREEN	DK GREEN		V2744	$150		
BROWN	DK BROWN	FAST BROWN	BLUE						
POLARIZED:									
HOYA	COPPERTONE	GREY	BROWN	GREEN	ROSE	V2762	$150		
MAUI JIM									
MIRROR:									
						V2761	$80		
TINT:									
		SOLID	GRADIENT	%		V2745	$40		
OTHER:									
UV COATING						V2755	$20		
FACTORY SCRATCH COAT		CLARITY SHIELD 2				V2760	$22 / $40		
EDGE POLISH		CLEAR BLUE FILTER	*MAUI JIM SHIPPING 14.50*			V2799	$20		
NW ADVANTAGE PACKAGE W/TRIVEX:									
SINGLE VISION $140		BIFOCAL $170		TRIFOCAL - POLY $190		PROGRESSIVE $250			
INSURANCE:		**COMMERCIAL**		**AFTER CATARACT SX**				**COPAY**	
AETNA	ATRIO SPECIAL NEEDS	BCBS	EBMS	CIGNA	PREMIER			**SUBTOTAL**	
MEDICARE	MODA	PACIFICSOURCE	PROVIDENCE	SPECTERA	SUPERIOR			**DISCOUNT**	
UNITED	VSP: SIGNATURE	CHOICE	ADVANTAGE	EXAM PLUS W/ ALLOWANCE				**BENEFIT**	
SEG HEIGHT:	**PDS:**	**POW:**						**TOTAL**	
NOTES:								**PD TODAY**	
								OWES @ PICKUP	

**SIGN OPTICAL PURCHASING POLICY **

Optical Purchasing Policy

Financial Policy

Insurance is a contract between you and your insurance company. In most cases, we are not a part of this contract. We will bill your insurance company on your behalf as a courtesy to you. To properly bill your insurance company, we require that you disclose all insurance information, including primary and secondary insurance, as well as any change of insurance information.

It is your responsibility to notify our office promptly of any patient information changes (ie, address, name, insurance information) to facilitate appropriate billing for the services rendered to you. Failure to provide complete and accurate insurance information may result in the entire bill being categorized as a patient's responsibility.

Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. If your insurance company is not contracted with us, you agree to pay any portion of the charges not covered by insurance, including but not limited to those charges above the usual and customary allowance.

When glasses or contacts are ordered, full payment is due at the time of order. **Frames purchased in the optical department are final sale, no refunds.** I understand that I am responsible for all financial obligations of optical services. If for any reason my account should become delinquent, I acknowledge responsibility for my outstanding account balance and for all related fees attributed to collecting my debt.

90 Day Acknowledgement Policy

I understand that it is my responsibility to have my glasses prescription filled in a timely manner and agree that any eyeglasses recheck after 90 days from the date of my exam is a billable office visit. Also, any changes in lenses after 180 days from the order date is at my own expense.

Frame Disclaimer - Patient Owned Frames Policy

We will take every precaution to ensure careful handling of a patient's frame. However, we are not liable for breakage / damage to any patient supplied frame. Use of such frames will be at patients own risk. If breakage / damage occurs, a different frame can be supplied or bought.

I have read the optical purchase policy and understand my responsibilities. By my signature I acknowledge, without exception, and accept the optical policy terms and conditions.

_____	_____
Printed Name	***Date of Birth***
_____	_____
Signature of Patient	***Date***