**San Pablo Optometric Center**

**14240 San Pablo Ave.**

**San Pablo, CA 94806**

**(510) 232-3060**

**Return Policy for Eyeglasses and Contacts Lenses**

All sales on prescription glasses and contact lenses are final. However, if there is a need of an adjustment to the prescription there are no extra charges within 90 days of purchase. There are no returns or exchanges on contact lenses unless, there is a manufacturer defect or an issue with the measurements.

All name brand frames are under manufacturer warranty for any manufacturer defects within a year from the date of purchase. This does not include any accidental damages or breakage to the frame. Although the manufacturer replaces the frame under warranty, the manufacturer charges shipping and handling fees of $25 for which the patient is responsible for.

**Policy for Returned Checks**

There is a fee of $30.00 for any returned checks which needs to be paid in addition to the original amount due within the 90 days.

**Receipt of Notice of Privacy Policies & Consent Form**

The *Notice of Privacy Practices* you have been given describes the uses and disclosures in detail. You are free to refer to this notice at any time before you sign this form. As described in our *Notice of Privacy Practices*, the use and disclosure of your health information for treatment purposes not only includes care and service provided here but also, disclosures of your health information as may be necessary and appropriate for you to receive follow-up care from another health professional. Similarly, the use and disclosure of your health information for purposes of payment include (1) our submission of your health information to a billing agent or vendor for processing claims or obtaining payments; (2) Our submission of claims to third party payers or insurers for claim review, determination of benefits and payment; (3) our submission of your health information to auditors hired by third party payers and insurers; and (4) other aspects of payment described in our notice of private practices. Our *Notice of Private Practices* will be updated whenever our privacy practices change. You can get an updated copy here at the office.

When you sign this consent document, you signify that you agree that we can and will use and disclose your health information to treat you, to obtain payment for our services and to perform health care operations. You also signify that you have also received a copy of our *Notice of Privacy Practices*.

You have the right to ask us to restrict the uses or disclosures made for purpose of treatment, payment or healthcare operations, but as described in our *Notice of Privacy Practice*, we are not obliged to agree to these suggested restrictions. If we do agree, the restrictions will not be bound on us. Our *Notice of Privacy Practices* describes how to ask for restriction.

By signing below, I agree that I have read this document and understand it. I consent to the use and disclosure of my health information for purpose or treatment, payment and health care operations. I acknowledge that I have received the *Notice of Privacy Practices* form.

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_\_