Triangle Family Eye Care

Thank you for choosing Triangle Family Eye Care as your eye care & eye wear specialists. We are very proud of the product and services we provide and are committed to providing you with clear & comfortable vision as well as maintaining the health of your eyes.

For your convenience ...

We do participate with many insurance & vision care plans. Some of these plans require you to pay a co-payment or to meet a deductible. We will be more than happy to explain your benefits and make sure you receive everything you are entitled to. **Your co-payments and fees for non-covered eye care and eyewear are due at the time of service.**

- We will file insurance claims for you and will need all of your proper information. Please have your insurance card along with the member's information with you at your visit.
- We will provide you with a statement to submit directly if we are not a provider.Your full payment for eye care & eye wear is due at time of service.
- We will make our best efforts to collect payment from your insurance or vision care plan. If your claim is denied we may contact you for your assistance. If we are unable to collect this payment or only partial payment is received we will again notify you as you are responsible for the balance due.

If you are dissatisfied with your eyewear product for any reason we will remake your lenses at no extra fee. Please understand refunds are not given as these are custom made lenses in your glasses.

Medicare Patients Only

- Triangle Family Eye Care is a participating provider with Medicare, however, Medicare pays only a portion of your bill. Unless you have secondary coverage in addition to Medicare, you are required to pay 20% of Medicare's allowable charge, any remaining portion of your annual deductible, and 100% of all non-covered services and optical goods at the time of service. If Medicare is not your primary insurance, please inform our receptionist when you arrive for your appointment.
  Your Initials: _____

I have read & understand all of the above. I consent to the use and disclosure of my health information for the purposes of treatment, payment, and healthcare operations. I acknowledge that I have been given the opportunity
to see and review the Notice of Privacy Practices from Triangle Family Eye Care.

_____ _____

Patient & or Responsible Party (Please Print & Sign)

Date