Crockett Eye Clinic
711 E. Goliad Ave Crockett, TX 75835
Phone: 936-544-3763 Fax: 936-544-7894
www.crocketteyeclinic.com

Name _____

Date _____

PAYMENT INFORMATION: Payment in full is expected at the time professional services are rendered. A down payment of half is required when ordering materials. We are happy to file for insurance payment when applicable. *Initial* _____

ACKNOWLEGMENT:

- If insurance is filed on my behalf, I authorize my insurance benefits to be paid directly to JA McCall Clinic (Crockett Eye Clinic) ***Initial*_____**

- I agree that unless JA McCall Clinic (Crockett Eye Clinic) and my insurer have a prior agreement, I am personally responsible for all non-covered services, co-pays and deductibles. ***Initial*_____**

- I authorize the release of medical information to insurance carriers or other physicians if it is deemed necessary by my optometrist for financial or consultative purposes.

  ***Initial*_____**

- I agree to provide 24 hr notice of any cancellation or rescheduling of an appointment. Without 24hr notice, there will be a $25 charge.

  ***Initial* _____**

- We will perform Optomap Retinal Imaging on ALL Annual Eye Exams for $20. If you cannot afford the $20, please inform your technician.

  ***Initial*_____**

HIPPA PRIVACY STATEMENT

This privacy statement represents the policies of Dr. John McCall Jr.,
and the staff of JA McCall Clinic (Crockett Eye Clinic).

HIPPA COMPLIANCE AKNOWLEGEMENT OF RECEIPT

I acknowledge that I received a copy of the privacy statement of JA McCall Clinic (Crockett Eye Clinic) and that I will receive a copy of my eyeglass prescription at the end of the exam. The eyeglass prescription will also be available through the patient portal.

Signature_____