Ocular
PROSTHETICS, INC.
STEPHEN E. HADDAD, B.C.O.

ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY

I, the undersigned patient, parent or guardian of a patient, authorizes payment of medical benefits to Ocular Prosthetics, Inc. for any services furnished to me by them. I understand that I am responsible for knowing and understanding my insurance policy including benefits, co-pays, deductibles, co-insurance, covered providers, especially services related to prosthetics. I understand that I am financially responsible for any amount not covered by my insurance carrier. I also authorize you to release to my insurance carrier or their agents(s), information concerning health care, advice, or treatment provided to me. This information will be used for the purpose of evaluating and administering claim benefits.

_____ _____
Patient or Guardian Signature Date

_____
Print Name

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I acknowledge that I have received the ***Notice of Privacy Practices*** from Ocular Prosthetics, Inc. I consent to the use and disclosure of my health information for purposes of treatment, payment, and healthcare operations.

_____ _____
Patient or Guardian Signature Date

_____
Print Name

PROSTHETIC EYE WARRANTY

Artificial eyes manufactured and sold by Ocular Prosthetics, Inc. of Los Angeles, CA carry a 90 day warranty against defects in materials or components of the prosthesis. We will repair or replace, at our discretion, free of charge, prosthetics covered under this warranty.

This warranty does not cover loss of the prosthesis, nor does it cover damage to the prosthesis as a result of abuse, misuse, or any other use not intended for its purpose as an ocular prosthesis. This warranty does not cover the prosthesis due to changes within the eye socket anatomy or surrounding area of the orbit.

Ocular Prosthetics, Inc. will notify all Medicare beneficiaries of warranty coverage, and will honor all warranties under applicable law. Warranty information will be provided to beneficiaries for prosthetics manufactured in our office.

_____ _____
Patient or Guardian Signature Date

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323.462.6004