POLICY ACKNOWLEDGMENT

By signing below, you acknowledge that you have received or reviewed a copy of Lakepointe Vision Center's current policies as listed below. These policies are subject to change without notice. Should our policies change, an updated copy will be provided to you at your next scheduled appointment. A signature is required to signify receipt of each updated policy. You may request a copy of these policies at any time. Please initial and sign to confirm that you have received these policies.

PATIENT: _____ (please print name)

Office Policy and Contact Lens Policy Initial: _____

Financial Agreement Initial: _____

Signature: _____Date: _____

****These forms are available on our website as well if you wish to review electronically****

If you would like a personal copy for your records, please take the packet located in the plastic folder behind this paperwork.