NORTH COUNTRY VISION CENTER
(518) 338-3080

Due to the custom nature of glasses, all prescription eyewear sales are final: No refunds or exchanges will be given. Payment is expected at time professional services are rendered and no refunds will be made for services.

Prescriptions:

- For prescriptions we fill written by doctors at North Country Vision Center – An office visit to recheck the prescription will be provided and if new lenses are necessary, they will be changed at no charge within 90 days of the examination. Re-check visits and/or new lenses after 90 days will be charged the usual fees.
- For prescriptions written by other doctors, if a new prescription is needed, we will re-do the lenses with the new prescription ONE time within 90 days of the exam. Any additional re-dos will be at the usual fees.
- For all Lenses-any option that is on the original lenses that are not wanted at the time of re-do will NOT be refunded
- For our prescriptions that are filled elsewhere, if a lens prescription change is needed after glasses are made, the new prescription will be provided at no charge within 90 days of the examination. We will NOT be responsible for any lens or frame changes incurred. Most reputable optical dispensaries allow doctor Rx changes at no charge, but it is up to the patient to inquire about such policies in advance of purchase
- Frames purchased at North Country Vision Center have a one-year manufacturer defect warranty. Normal Wear and tear, damage by accident or loss are not covered by the warranty. We reserve the right to inspect and determine if the frames can be replaced under warranty.
- The utmost care will be taken in the handling of patients' own frame(s), but since the frame is not new or new but not purchased at North Country Vision Center, North Country Vision Center will not be responsible for any damage that might occur.

Lenses

- Lenses with ultra or super-premium Anti-reflective (AR) coatings have a 2-Year Warranty against coating defects such as flaking or peeling. Lenses made by Insurance laboratories may have a 1-year warranty against such defects. We reserve the right to inspect and determine if the lenses can be replaced under warranty.

Contact Lenses

- Only boxes that are unopened in resalable condition – Free of any markings, dents, or damages will be exchanged or refunded.

Contact Lens Exams

- Are to be completed within 3 months of the comprehensive examination. There may be additional office visit charges if the patient fails to come back for their follow up appointment(s) to finalize their prescription.

Insurance

- Insurance claims cannot be backdated. All services and orders are billed on appointment date.
- Knowledge of benefits and eligibility is your responsibility. All insurance plans are unique; and staff may not have all the information specific to your plan available to them before your visit.
- **All co-pays are due at the time of service. If not paid, a $10.00 service fee will be applied to your account.**

Patient Responsibilities

- An adult is required to accompany all children under the age of 18. The adult accompanying the minor is responsible for payment of services regardless of the relationship or financial arrangement.
- We have the right to dismiss a patient at any time from our practice. Without notice we reserve the right to terminate our relationship with you at any time without notice or reason.
- **No-Show** If you do not show for 3 appointments in a row you will no longer be seen at this office.

We are not responsible for glasses or contacts that are not picked up within 90 days.
Payments or deposits will NOT be refunded.
Any other unusual circumstances that are not mentioned above will be handled on a case-by-case basis.

By signing below, I authorize:
I have read/or understood the Notice of Privacy Practices and I further consent to the release of my health information for purposes of treatment, payment, and health care operations and as authorized or required by law in the circumstances described in the Notice of Privacy Practices.
Patient
Name: _____DOB: _____
Patient Signature_____Date_____
(Parent or Guardian)