Genia G. Beasley, OD, FAAO, FCOVD
Board Certified in Vision Development and Rehabilitation
Fellow, American Academy of Optometry
Fellow, College of Optometrists in Vision Development

Office Policies For Your Information

Prior to your appointment, please mail or fax any additional information to the office, including reports from other professionals (previous eye exams, psycho-educational reports, occupational therapy evaluations, etc.) so Dr. Beasley can be familiar with your child's prior therapies and evaluations.

Missed Appointment Fee:
Your initial appointment is reserved for one hour with the doctor. There is a **missed appointment fee of $60.00** for appointments missed without 24 hours notice of cancellation. This missed appointment fee is not reimbursable through insurance, and applies to all appointments with the doctor including progress evaluations and visual information processing testing. To avoid a missed appointment fee, call and speak to our staff during office hours.

Insurance Policy:
Please note that All Ages Vision Care and Dr. Beasley are considered out of network, and are not contracted as a provider with any insurance company. Filing for insurance reimbursement is the responsibility of the member; however, we can assist you with this process by providing you with the proper documentation i.e. letter of medical necessity/explanation. The diagnosis/diagnoses and procedure code/codes will appear on your statement.

Please note: Medicare and Medicaid members; we do not issue a CMS form for reimbursement through these insurance companies. A statement from All Ages Vision Care will be issued.

Please note: The Champus Maximum Allowable Charges (CMAC) apply for Federal Services members. By electing to have treatment at All Ages Vision Care, you are also electing to be responsible for charges exceeding the applicable CMAC amount.

Full payment is due at time of service. I understand that I am financially responsible for all charges whether or not paid by insurance. By signing below, I am agreeing to be responsible for all charges.

My signature also indicates that I have been made aware that a copy of the HIPAA Notice of Privacy Practices is available to me upon request.

Responsible Party (print) _____

Signature _____ **Date** _____