

SIGNATURE ON FILE, ASSIGNMENT OF BENEFITS, FINANCIAL AGREEMENT

Patient Name (print)

1. RELEASE OF INFORMATION:

Pro Optix Eye Care may disclose all or part of my medical record and/or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease, or HIV, to any person or corporation (1) which is or may be liable or under contract to Pro Optix Eye Care for reimbursement for services rendered, and (2) any health care provider for continued patient care. A copy of this authorization may be used in place of original.

2. Estimates:

We invite you to discuss charges with our office freely. How much you will be charged will, of course, depend upon the services provided. Office personnel will, however, try to give you the best estimate based upon consultation with clinical staff prior to the services provided.

3. No Insurance:

If you do not have insurance, all charges are due and payable at the time of service.

Billing:

We accept assignment on all insurance carriers, and will prepare and send claims to primary and secondary payers for you. Once your carrier(s) have responded, any unpaid portion after managed care discounts will be released to the patient's responsibility and will be due upon receipt. In the event your health plan determines a service to be "not covered" or pre-existing, you will be responsible for the complete charge which will be released to patient responsibility on your monthly statement.

4. NON-COVERED SERVICES:

I understand that Pro Optix Eye Care contracts with health care service plans (i.e., HMO's, PPO's) relate only to items and services which are "covered" by health care service plans. **Accordingly, the undersigned accepts full financial responsibility for all items or services, which are determined by the health care service plans not to be covered, including refraction fee (which is not covered by Medicare).** I agree to cooperate with Pro Optix Eye Care to obtain necessary health care service plan authorizations.

5. Referral Authorization

Some managed care plans require you to obtain a referral number prior to your initial visit, and require you update your referral number periodically if you are continuing to be treated in our clinic. It is your responsibility to obtain the referral number through your primary care physician prior to your initial visit, and for any subsequent office visits. Your insurance company may refuse to pay for services performed without a valid referral number. You will then be held responsible for these charges. We will see that referrals are renewed or extended during the course of any on-going- treatment. However, should you interrupt our treatment and then restart, it will be your responsibility to verify that a valid referral is still in effect, and if not, obtain a new one. If you change your primary care physician, or change insurance, it will be your responsibility to obtain a new referral in accordance with your policy changes.

6. Form of Payment:

We accept MasterCard, Visa, American Express and Discover for your convenience. If you are an established patient and you feel that you cannot pay the entire amount of your charges at the time of your visit, please make arrangements to speak with our Billing Manager prior to your visit, so that a payment plan can be discussed. We will try to work with you as much as possible.

7. FINANCIAL AGREEMENT: I agree that in return for the services provided to me by Pro Optix Eye Care, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to Pro Optix Eye Care for payment. IF my account is sent to an agency for collection, I agree to pay collection expenses and reasonable attorney's fees as established by the court and not by a jury in any court action. I understand and agree that if my account is delinquent, I may be charged interest at the legal rate. Any benefits of any type under any policy of insurance are hereby assigned to Pro Optix Eye Care. If co-payments and /or deductibles are designated by my insurance company or health plan, I agree to pay them to Pro Optix Eye Care. However, I understand that I am primarily responsible for the payment of my bill.

8. *Care Credit:

We accept Care Credit for your convenience.

9. Product Ordering:

We require 50% of total payment before any product is ordered, which includes frames, lenses and contact lenses. The remaining balance must be paid before dispensing.

Patient Signature or Authorized Party

Date