1. **ASSIGNMENT OF BENEFITS:** I request payment of authorized benefits be made directly to Associated Eye Care for services furnished to me by Associated Eye Care. I understand my signature requests that payment be made and authorizes the release of health records and other information related to my health care services to any health plan, including Medicare, my insurance company or health maintenance organization, other payers, payer network organizations, including accountable care organizations in which my providers participate, and the contractors and third party administers of any of these parties, for purposes of payment or health care operations. Any benefit of any type under any policy of insurance insuring the patient, or any other party liable to the patient, is hereby assigned to Associated Eye Care. I understand that Associated Eye Care has contracted with several health care plans. If contracted, Associated Eye Care accepts the charge determination of the carrier as the full charge, and I am responsible for any copay, deductible, coinsurance, or non-covered services. Insurance required copays are due at the time of service. Any coinsurance and deductible are based upon the charge determination of the carrier. I understand that I am individually obligated to pay the full charges of all services rendered to me by Associated Eye Care if I belong to a plan not contracted with Associated Eye Care.

2. **NON-COVERED SERVICES:** I understand that Associated Eye Care's contracts with health care service plans relate only to items or services that are "covered" by the health care service plans. Accordingly, the undersigned accepts full financial responsibility for all items or services, which are determined by the health care services plans not to be covered. (I.e., Medicare patients – routine exams and refractions.) The undersigned agrees to obtain necessary health care service plan authorizations and/or referrals prior to the appointment. Payment for non-covered services is due prior to services being rendered.

3. **RELEASE OF INFORMATION:** I consent to the release of my health records and other information related to my health care services, created, received, and maintained by Associated Eye Care to any person or corporation (1) which is or may be liable or under contract with Associated Eye Care for reimbursement for services rendered, and (2) any health care provider involved in my treatment or continued care.

4. **FINANCIAL AGREEMENT:** I agree that in return of the services provided to the patient by Associated Eye Care, I will pay all co-payments, deductibles, and other charges not covered by my health plan upon receipt of the billing statement, and/or I will make financial arrangements satisfactory to Associated Eye Care for payment. If an account is sent to an attorney 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. It is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill. I understand that any alterations to this form, including strikethroughs, will deem the form invalid and the undersigned and/or patient will be responsible for payment in full prior to services being rendered. This agreement is valid for one year from the last dated signature.

SIGNATURE _____ DATE: ___/___/___

PRINTED NAME _____