Description of Services, Release of Information, Financial Agreement

_____ _____

Beneficiary Name Date of Birth

Description of Non-Covered Services:
I understand that the following services provided by our office may be considered non-covered services by your health care service plan:

- Refractive Surgical Pre-Operative Consultation
- Refractive Surgery for the reduction of myopia, hyperopia and/or astigmatism and presbyopia.

Accordingly the undersigned accepts full financial responsibility for all items of services which are determined by the health care service plans not to be covered. Examples of non-covered services include, but are not limited to, services not specified as being covered in the patient's contact with a health service plan or in the benefit summary the health service plan furnishes to the patient; and treatment or tests not authorized by the health care service plan. The undersigned agrees to cooperate with our office to obtain necessary health care service plan authorizations.

Description of Covered Services:
Our office contracts with health care plans (e.g., HMS's, PPO's, Medicare) to provide services to patients that those plans consider "covered" or medically necessary. Examples of these services include punctal occlusion for the treatment of dry eye, diagnostic testing such as corneal topography and evaluation of patients with cornea-related medical diagnoses (e.g. post corneal transplant, corneal disease, surgically induced refractive error). If the services provided to the patient by our office are deemed to be covered by your health insurance, you will be responsible for any applicable co-payments or deductibles as defined by your insurance plan.
Our office maintains a list of health care plans with which it contracts. Our office has no contract expressed or implied with any plan that does not appear on that list. The undersigned agrees that they are individually obligated to pay the full charges of all services rendered to me by our office if I belong to a plan that does not appear on the above mentioned list.

Release of Information:
Our office may disclose all or any part of my medical record and/or financial ledger to any person or corporation (1) which is or may be liable or under contract to our office for reimbursement for services rendered and (2) any health care provider for continued patient care. Our office may also disclose on an anonymous basis any information concerning my case, which is necessary or appropriate for the advancement of medical science, medical education, medical research, for the collection of statistical data or pursuant to State or Federal law, statute or regulation.

Financial Agreement:
I agree that in return for the services provided to the patient by our office, I will pay my account at the time service is rendered or will make financial arrangements satisfactory 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. I understand and agree that if my account is delinquent, I may be charged interest at a legal rate. 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 our office. If co-payments or deductibles are designated by my insurance company or health plan, I agree to pay them to our office. However, it is understood that the undersigned and/or the patient are primarily responsible for payment of my bill.

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Signature of Patient or Authorized Party Date