Financial Agreement and Consent to Treatment

The following contains important information concerning your financial responsibilities and your treatment at EyeLand Vision. Please read it carefully.

1. FINANCIAL AGREEMENT: I understand payment for professional services, including but not limited to, comprehensive eye exam, contact lens fitting and medical office visits, is due in full at the time services are rendered. Professional fees are non-refundable. Full payment must be made for all materials, including but not limited to frames, ophthalmic lenses and contact lenses before they are ordered. All services are based on medical necessity, and therefore, it is impossible for EyeLand Vision to provide a total cost prior to evaluation. I understand EyeLand Vision will bill my insurance as a courtesy, but this is not a guarantee that my insurance will pay for services rendered or materials provided. It is my responsibility to know my insurance benefits and coverage. I am responsible for all co pays, deductibles, and services or materials not covered by my insurance. In the event it becomes necessary for EyeLand Vision to enlist the services of a collection agency and/or legal assistance, I will be responsible for any collection expenses and reasonable fees.

2. NON-COVERED SERVICES: I understand that EyeLand Vision's agreements with vision and health insurance plans relates only to items and services which are "covered" by the insurance plan. I accept full financial responsibility for all items or services, which are not covered by my insurance, including the refraction fee.

3. MEDICARE and Medicaid: I request that payment of authorized Medicare or Medicaid benefits be made on my behalf to EyeLand Vision for services furnished me by EyeLand Vision. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. EyeLand Vision accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare Carrier.

Authorization to Bill: I have read and understood the above information and agree to comply with these terms. I authorize my insurance company to make payment directly to EyeLand Vision for services and/or materials rendered. I authorize EyeLand Vision to release information about me or my dependents necessary to process any and all claims for reimbursement on my behalf.

Authorization to Treat: I also authorize EyeLand Vision, its agents, and employees, and their agents and employees (collectively referred to as "Healthcare Providers") to furnish optometric care and services, including but not limited to, diagnostic tests, examinations, and other medical and/or surgical procedures, which is deemed necessary in the course of my care.

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Type First and Last Name Date

By entering my first and last name, I understand I am constituting a legally binding electronic signature which I accept has the same validity and meaning as my handwritten signature.