BILLING AND COLLECTIONS POLICY

- I have been informed of Cornerstone Eyecare's Notice of Privacy Practice.
- I realize that Cornerstone Eyecare is filing my insurance as a courtesy to me. In the event that my insurance
- company does not pay as expected I will be responsible for the balance due.
- I understand that past due balances will be assessed a $30 delayed payment charge at 120 days past due and my
- account will then be sent to a collections company.
- I fully understand that insurance copays and all non-covered fees are due at the time of service. I attest that all
- information on this form is accurate and current. I hereby authorize Cornerstone Eyecare to release all
- information necessary to secure the payment of benefits.
- I request that payment of authorized insurance benefits be made on my behalf to my optometrist for any
- services rendered.
- I authorize the use of my signature on all insurance submissions.

I understand if I have an unpaid balance to Cornerstone Eyecare and do not make satisfactory payment arrangements, my account may be placed with an external collection agency. I will be responsible for reimbursement of any fees from the collection agency, including all costs and expenses incurred collecting my account, and possibly including reasonable attorney's fees if so incurred during collection efforts.

In order for Cornerstone Eyecare or their designated external collection agency to service my account, and where not prohibited by applicable law, I agree that Cornerstone Eyecare and the designated external collection agency are authorized to (i) contact me by telephone at the telephone number(s) I am providing, including wireless telephone numbers, which could result in charges to me, (ii) contact me by sending text messages (message and data rates may apply) or emails, using any email address I provide and (iii) methods of contact may include using pre-recorded/artificial voice message and/or use of an automatic dialing device, as applicable.