The undersigned, jointly and severally, agree to pay all charges for professional services rendered to the patient. The undersigned understands that these charges are in addition to charges by a hospital or other medical professional rendering services to the patient.

The undersigned promises to pay the charges in full at the time a bill is presented, unless other terms have been agreed to in writing. In the event prompt payment is not made, the undersigned agrees that the account may be referred for collections. In that event, the undersigned agrees to reimburse Virginia Beach Eye Center, P.C. for any and all fees associated with collection and legal activities. Collection agency fees are based on a percentage of the debt, up to a maximum of 33%, all costs, and expenses, including reasonable attorney's fees, associated with collection efforts. If your check is returned for any reason, you are responsible for the amount due as well as the $40.00 returned check fee.

If the patient has provided insurance information, Virginia Beach Eye Center, P.C., may, but is not required to assist the patient in the filing of a claim form.

I request that payment of authorized Medicare/other insurance company benefits be made either to me or on my behalf to Samuel N. Garrett, M.D., Christopher J. Kurz, M.D., or Joy Tomko, O.D. at Virginia Beach Eye Center, P.C. for any services furnished to me by that company. I authorize any holder of medical information about me to release to HCFA or other insurance companies any information needed to determine benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If item 12 of the HCFA-1500 claim form is completed, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare/other insurance company assigned cases, Virginia Beach Eye Center, P.C. agrees to accept the charge determination of the Medicare/other insurance company as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare/other insurance company.

I understand that ROUTINE EYE EXAMS and REFRACTIONS are usually *non-covered* services with most insurances, and I will be *financially responsible* for charges incurred.

SIGNATURE____________________________________ DATE__________________________

I understand that my vision may become blurry if my pupils are dilated. Blurring usually only occurs at near, but may also occur with my distance vision. I understand the above and have made my desired arrangements for leaving the office today.

PLEASE INITIAL ________________

EMERGENCY INFORMATION

NEAREST FAMILY MEMBER NOT LIVING WITH YOU______________________________

TELEPHONE ____________________________ RELATIONSHIP ______________________