ADVANCED SIGHT CENTER, INC

FINANCIAL POLICY, ASSIGNMENT OF BENEFITS, RELEASE OF INFORMATION, AND RIGHTS & RESPONSIBILITY

WE ACCEPT CASH, CHECKS AND VISA/MASTERCARD/DISCOVER.

Thank you for choosing Advanced Sight Center, Inc for your care. We are committed to providing you with the best possible services.

1) Financial Policy

Your medical coverage is a contract between you and your insurance carrier. While we will bill your insurance carrier as a service to you, ultimately you are responsible for any outstanding balance on your account with us. We have made prior arrangements with many HMOs, insurance companies, and other medical plans to accept assignment of benefits. We will bill those plans for which we have an arrangement and will only require you to pay the authorized co-payments, deductibles, or co-insurance at the time of service. It is our office policy to collect all co-payments on the day of the appointment. All co-insurance and deductibles are required to be paid before service is rendered. If you have insurance coverage with a plan with which we do **not** have a prior arrangement, we will expect payment at the time of service, unless you or your insurance carrier has made other arrangements in advance.

We may have an agreement with your benefit plan or by law specifying the amounts we may charge for the services we are rendering to you. We will collect $_________ as a deposit toward the amounts not covered by your benefit plan. Any balance of charges not covered by your insurance company will be due after Advanced Sight Center, Inc receives an Explanation of Benefits (EOB) from your insurance carrier.

In the event that your health plan determines the medical care received to be a "non-covered" service, you will be responsible for the entire charge. Even though Medicare or your insurance carrier may not pay for these services, you are advising Advanced Sight Center, Inc to proceed and you acknowledge that you are responsible for the entire charge, including late charges. Payment will be due upon receipt of a statement from Advanced Sight Center, Inc.

If your service is covered by a No-Fault or Worker's Compensation Insurance, you shall not be required to pay anything until your insurance company processes your claim for the services provided by Advanced Sight Center, Inc.

If the patient is a minor then you, as the minor's parent (or legal guardian), are guaranteeing full payment of the entire charge.

2) Assignment of Benefits

I hereby grant lien rights and assign to Advanced Sight Center, Inc any and all rights and benefits I have or may have with respect to any reimbursement Advanced Sight Center, Inc may be entitled to under my current insurance policy(ies) as payment toward the total charges for the services rendered to me by Advanced Sight Center, Inc. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER SUCH POLICY(IES) for the services I received at Advanced Sight Center, Inc. This payment will not exceed my indebtedness to Advanced Sight Center, Inc. I agree to pay, without delay, any and all outstanding balances remaining on my account after my insurance carrier makes this insurance payment to Advanced Sight Center, Inc.

If my insurance carrier will not pay Advanced Sight Center, Inc directly, I agree that when I receive the reimbursement check from my insurance carrier, I will then, without delay, use that money to pay Advanced Sight Center, Inc for any and all outstanding balances remaining on my account relating to the services I received from Advanced Sight Center, Inc.

A photocopy of this Assignment shall be considered as effective and valid as the original on my file with Advanced Sight Center, Inc.

I authorize Advanced Sight Center, Inc to initiate a complaint to the insurance commissioner for any reason on my behalf. I understand that Advanced Sight Center, Inc is not required to do so.

3) Release of Information

I hereby authorize Advanced Sight Center, Inc to furnish and obtain my health care information from physicians and other healthcare providers as required to carry out the diagnostic testing, payment and healthcare operation of Advanced Sight Center, Inc. I agree to indemnify and hold Advanced Sight Center, Inc harmless from and against any injury or loss arising out of or resulting from the release and/or acquisition of such information. I request that a photocopy and/or fax of this release be accepted with the same authority as that of the original on file at Advanced Sight Center, Inc.

4) Rights and Responsibility

I have been given a copy of Advanced Sight Center, Inc's Rights and Responsibilities and Privacy Notice Statement and understand its content.

I have read, understood and agreed to the terms of this document. All my questions or concerns have been answered to my satisfaction prior to signing below.

____ **Date**:_________________________

(Signature of Patient)