PRECISION EYE CARE

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SIGNATURE ON FILE, ASSIGNMENT OF BENEFITS, FINANCIAL AGREEMENT

I request that payment of authorized benefits be made to either me or to Precision Eye Care on my behalf for services furnished to me by the provider. I authorize the release of my medical information by or between any of my treating physicians and my health benefits payer (insurance company) or any other entity, including but not limited to third party administrators, management companies and provider networks involved with Precision Eye Care.

I agree that in return for services provided by Precision Eye Care, I will pay my account at the time service is rendered including all deductibles, co-payments, coinsurances and non-covered services. If my account is sent to a collection agency or to an attorney for collections, I agree to pay collection expenses and/or reasonable attorney fees as established by the court.

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Patient Signature (If a minor, Parent/Guardian) Date