ANNANDALE EYE | COKATO EYE | LITCHFIELD EYE

Office Policy & Financial Agreement Signature

Assignment of Benefits

I, the undersigned, authorize Annandale Eye Clinic, Inc., and Cokato Eye Center, Inc., its physicians, and/or employees to apply for benefits on my behalf for services rendered to me, effective from the date on the signed financial policy, and for any future visits thereafter. I request that payment from my insurance carrier be made directly to Annandale Eye Clinic, Inc., and Cokato Eye Center, Inc. I, the undersigned, also understand that I am financially responsible for all charges not covered by my insurance and/or Medicare. I further understand that my health insurance may not cover all services, including but not limited to: Dry Eye services, refractions, RHA retinal exams, comprehensive eye exams, contact lens evaluations, eyeglasses/contact lenses, OCTs, visual fields, and other ancillary services. I acknowledge that some of these services may be necessary for the completion of the evaluation.

I have read and understand this policy and that the practice requires my signature and I agree to be bound by its terms. I understand I may ask for a copy of this policy which I signed. I also understand and agree that this agreement will need to be signed during each new year, or when such terms are amended by the practice, at which point I will need to sign the new policy.

Print Name of Patient: _____ *Date of Birth:* _____

*Signature of Patient (or responsible party):*_____

Printed Name and Relationship of Responsible Party (if other than Patient):

_____

*Today's Date:*_____

Annandale Eye
500 Elm St E,
Annandale, MN 55302
(320) 274-3701

Cokato Eye
115 Olsen Blvd #300,
Cokato, MN 55321
(320) 286-5695

Litchfield Eye
135 N Sibley Ave,
Litchfield, MN 55355
(320) 593-3100