ANNANDALE EYE | COKATO EYE | LITCHFIELD EYE

Office Policy & Financial Agreement Signature

Assignment of Benefits

I, the undersigned, authorize Annandale Eye Clinic, Inc./Cokato Eye Center, Inc./Litchfield Eye Center, 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 there on. I request that payment from my insurance carrier be made directly to Annandale Eye Clinic, Inc./Cokato Eye Center, Inc./Litchfield Eye Center. 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 exam, comprehensive eye exams, contact lens evaluations, eyeglasses/contact lenses, OCT's, Visual Fields, and other ancillary services; some of these services are 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:_____