CAROLINA EYECARE PHYSICIANS, LLC

FINANCIAL RESPONSIBILITY AND WAIVER/RELEASE

I understand that it is the patient's responsibility to supply CAROLINA EYECARE PHYSICIANS, LLC with any current insurance information and/or any referral authorization forms that may be necessary for my insurance. I am aware that if I have a routine diagnosis my Insurance may not cover this appointment. If this account results in collection agency involvement, the undersigned guarantor agrees to pay all legally allowed interest and associated fees. I authorize CAROLINE EYECARE PHYSICIANS, LLC to receive all payments for medical services rendered to my dependents or myself. These authorizations will remain on file for all future treatment. I AM AWARE THAT I AM RESPONSIBLE FOR ANY UNPAID BALANCES.

I understand that Medicare and most Insurance companies do not cover standard care or eye refraction (eyeglass prescriptions) and that I will be fully responsible for these charges. I understand that insurance companies require beneficiaries to pay deductibles, company insurance, co-payments, and any non-covered services at the time services are rendered.

Most insurance companies do not cover the contact lens fitting or contact lens modification. The contact lens modification is a yearly charge that is separate from the eye exam charge. I understand that I am responsible for this additional charge.

I understand that a comprehensive eye exam involves dilation of the pupil, which may temporarily blur my vision for several hours. I recognize that operation of a motor vehicle after dilation may be hazardous and I have made appropriate arrangements.

IT IS CUSTOMARY TO PAY FOR SERVICES WHEN RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE. WE GLADLY ACCEPT CASH, CHECK, MC, VISA, AMERICAN EXPRESS, AND DISCOVER.

1) Date: _____ Signature _____

I authorize CAROLINA EYECARE PHYSICIANS, LLC to obtain information from other physicians that they may feel is beneficial in their evaluation or treatment. I authorize the physicians of CAROLINE EYECARE PHYSICIANS, LLC to furnish information to insurance carriers or other doctors concerning my illness and treatment. They may also obtain pre-certification and prior authorization when necessary.

2) Date: _____ Signature _____

Reviewed by: _____