CENTER FOR SIGHT

Financial Agreement and Lifetime Signature Authorization

Center For Sight, P.L. and Laser and Surgical Services at CFS LLC (CFS) are privately-owned medical facilities that provide medical services on a fee-for-service basis. CFS relies solely on insurance reimbursement and patient payment(s) for services rendered in good faith. CFS receives no federal, state or other third-party funding; as such, CFS does not have provision for providing on-going indigent care. The following Financial Agreement is developed in accordance with Office of Inspector General (OIG) guidelines as well as all applicable State and Federal reimbursement guidelines.

Upon obtaining a copy of your insurance card(s), CFS will verify your eligibility and benefits including deductibles, copayments, coinsurance responsibility, etc under your health insurance company, and CFS will submit claims for all medically necessary services to your health insurance company. Please note that payment is ultimately due from you in the event that your insurance company denies payment for any service(s); i.e. termination of coverage, coordination of benefits, non-payment of premium, etc…

Deductibles, coinsurances, and any non-covered services are the responsibility of the patient. To the extent possible and feasible, all patient financial responsibilities are payable at the time of service and / or prior to surgical procedures. Not all health insurance companies publish their (allowable) fee schedule; therefore coinsurance percentages cannot always be accurately calculated for pre-payment. A CFS statement will be sent to you after your health insurance has processed your claim(s); the balance due will compare to the Explanation of Benefits you will receive from your health insurance company. Should you dispute any amount on your Explanation of Benefits / statement, please contact your health insurance company member services for clarification of your benefits.

> *Please note that CFS medical providers are ethically obligated to assign diagnosis code(s) as indicated by the provider's diagnostic findings and in accordance with prudent medical standards. It is therefore inappropriate to request that a diagnosis be changed in the event your health insurance plan denies coverage at their discretion. Any such request will be denied; to comply would constitute insurance fraud and misrepresentation of the medical documentation relative to your care.*

Copayment(s), as stipulated by your health insurance company, are due on the date of service.

Please note that OIG guidelines (FR Vol. 65, No. 194, Oct.5, 2000) relative to anti-kickback statutes, as well as contractual obligations to the health insurance companies from whom CFS will seek reimbursement for medical services, prohibit the routine discounting of published fees, "insurance-only billing" or waiver of any insurance-assigned charges otherwise due from the patient.

Self-Pay: In the event that (1) you are uninsured, (2) CFS and / or its affiliated facilities does not have a participating relationship with your health insurance plan(s), or (3) you elect to have non-covered medical services (ie cosmetic or other services determined by your health insurance plan to be "not medically necessary", etc), CFS accepts self-pay patients with this signed agreement that payment is due on the day services are rendered or in the case of surgical procedures, payment is due prior to the surgical procedure(s).

CFS does not accept litigated cases and services are not provided on a contingency basis under any circumstances.

CFS is not a banking institution and does not assess finance charges to cover the operational cost of managing payments by installment; therefore, no internal financing options (i.e. budget or other installment plans) can be extended.

For your convenience, CFS accepts cash, check, money order and credit cards. In addition, CFS offers financing options through CareCredit.

I understand all of the terms defined above; I consent to receiving treatment under the stated terms and I agree to honor all of my financial obligations to Center For Sight. My signature below constitutes my Financial Agreement and Lifetime Signature Authorization.

Patient Name	**Date**	**Patient / POA Signature**	
CFS Employee Name	**Date**	**CFS Employee Signature**	

Failure to honor your financial obligations to CFS in accordance with this signed Agreement will result in your account being referred to Collections and termination of the treatment relationship in accordance with the regulations that govern ethical medical care.

Effective 7/1/2011