SOLL EYE

Financial Assignment and Agreements

I request that payment of authorized Medicare and /or insurance benefits be made on my behalf to Soll Eye for any services furnished to me by them. I authorize any holder of medical information about me to release to the Health Care Financing Administration, it's agents, or any other insurance carrier I may have, any information needed to determine these benefits or the benefits payable for related services. This assignment will remain in effect until revoked by me in writing.

I understand that I am financially responsible for all charges not covered by insurance. This includes any deductibles or co pays.

Soll Eye participates in many insurance plans. We do our best to learn as many of their requirements as possible.

However, it's not always possible. Please make sure that you understand your insurance and their requirements.

Medical insurances (ie. Medicare) do not pay for the examination required for glasses (refraction). I agree to be personally and fully responsible for payment.

I authorize Soll Eye to communicate with me by phone, answering machine, written correspondence or E-mail at home or business regarding appointments, care or billing.

I agree to the release of my medical information to my personal physician(s) or optometrist (s).

I give permission to discuss my medical information with the specific individuals named below: (ie. Spouse, adult children, care giver, emergency contact)

1._____
2._____

I acknowledge that a copy of Soll Eye privacy policy has been provided to me for review and that a copy is available upon my request.

I understand the above and agree to abide by the regulations of my insurance company and the policy of Soll Eye.

Signature: _____ (Patient or Legal Guardian)

Date: _____

Witness: _____ Date