SERVICES RENDERED

The Undersigned, jointly and severally, agrees to pay all charges for professional services rendered to the patient. The Undersigned understands that these charges are in addition to charges by a hospital or other medical professional rendering services to the patient.

The Undersigned promises to pay the charges in full at the time a bill is presented, unless other terms have been agreed to in writing. In the event prompt payment is not made, the Undersigned understands that the account may be referred for collections action. Typically, accounts for ophthalmology services will be turned over for collections if balances continue to be due 90 days following your date of service. However, exceptions (that reduce or extend this 90 day period) may be made when reasonable in our judgment on a case-by-case basis or when dictated by requirements set forth by your insurance carrier. Before turning your account over to collections, we will attempt to contact you.

Monies due on unclaimed optical orders will be turned over to collections as early as 30 days after orders are placed. If optical orders are modified after orders are placed with optical labs, patients may owe a balance on the original order if our optical lab has already cut lenses, etc.

If your account is referred to an attorney or other collections agency, you agree to pay all collections cost including attorney fees of thirty-three and one-third percent (33 1/3%) of the principal amount turned over for collections. In addition, you agree to pay interest at the rate of .75 percent per month (9.00% per annum) on all unpaid balances.

If the patient has provided insurance information, Atlantic Eye Consultants, P.C., may, but is not required to, assist the patient in the filing of a claim form.

I request that payment of authorized Medicare/Other insurance company benefits be made either to me or on my behalf to Aris P. Delianides, M.D. at Atlantic Eye Consultants, P.C. for any services furnished to me by that company. I authorize any holder of medical information about me to release CMS or other insurance company any information needed to determine benefits payable to related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If item 9 on the CMS claim form is completed, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare/other insurance company assigned cases, Atlantic Eye Consultants, P.C. agrees to accept the charge determination of Medicare/other insurance company as the full charge, and the patient is responsible only for the deductible, co-insurance and non-covered services. Co-insurance and the deductible are based upon the charge determination of Medicare/other insurance companies.

Signature ______________________________ Date ________________________