Chart #____

Southern Eye Specialists P.C.

Billing Agreement

By signing this form I am stating that I understand that I will be financially responsible for any amounts not covered by my insurance. I also understand that I will be responsible for any co-payments and deductibles required by my insurance company at the time services are rendered. I further understand that a fee will be added to my bill should I not pay my co-pays or co-insurance at the time of service and a statement is sent for payment.

Authorization: I authorize payment of my medical benefits to Southern Eye Specialists P. C. I also authorize the release of any information necessary to process my claim(s).

I authorize my physicians to release the results of my evaluations and/or test to my referring and/or medical doctor and, when Workmen's Compensation is involved, I authorize the release of records and medical information to my employer and/or any company acting on behalf of my company.

Agreement to pay: I understand that if any account becomes delinquent, it will be placed with a collection agency at the discretion of Southern Eye Specialists, PC. If a patient's balance has not been paid within 120 days, all unpaid balances will be deemed negligent, and I agree and hereby consent that I will be responsible for reasonable collection costs and attorneys fees in the amount of 33 1/3% in addition to the outstanding balance, and the cost of court incurred by Southern Eye Specialists P.C., in the collection of same, whether such outstanding balance is satisfied prior to, after initiation of a lawsuit, or after a judgment has been issued in a lawsuit. I agree and hereby consent that any lawsuit and/or legal proceeding surrounding the outstanding balance and debt, and fees and cost thereon, shall be initiated and litigated in the court of appropriate jurisdiction of Houston County, Alabama, and I hereby waive any and all defenses and/or herein and affirmatively acknowledge that I have read the same before signing. I also understand that the initiation of such proceedings can result in a negative impact on my credit rating. For all accounts requiring a statement, a $5.00 per month fee will be added to my total outstanding balance. For payments that result in a returned check, there is a $25.00 charge that will be added to the patient's balance. Furthermore, I agree that if a cell phone number has been provided I can be contacted regarding my balance on said cell phone. Additionally, if I reside in Florida I agree to waive my rights to any exemption that would prohibit a wage garnishment should same become necessary to secure payment of any outstanding balance. I also agree that at any time if my balance has not been paid according to policy, I understand my credit history will be investigated and thoroughly reviewed. By signing below, I consent to the terms contained herein and affirmatively acknowledge that I have read the same before signing.

Patient Signature ____Date ___________________

Patient/Responsible Party signature: _____________________________ Date ___________________

Witness: ____ Date __________________