C-U Eyecare, LLC

2008 Round Barn Rd. Champaign, IL 61821

SIGNATURE ON FILE

This Notice Describes Your Financial Obligations.

PLEASE VIEW IT CAREFULLY.

1. Financial Agreement: I understand that I am responsible for all charges at time of service and that there is no guarantee of payment from any insurance company or other payer. I understand that some routine services are not covered by my insurance and that I am financially responsible for all charges at time of service. I agree to pay all charges for the services provided by C-U Eyecare, LLC which are not paid by my health insurance or other payer. This includes copays, deductibles, glasses, contact lenses, and any denied claims. I agree to pay all reasonable legal expenses necessary for collection of any debt.

2. Assignment of Insurance Benefits: I hereby assign and request that payment of all insurance benefits be made directly to C-U Eyecare, LLC. Furthermore, I understand that I am financially responsible for any and all charges incurred while under the care of this office.

3. Authorization for Release of Information and Privacy Statement Notice:
   C-U Eyecare, LLC may release information from my medical records to any health care provider involved in my care and treatment. C-U Eyecare, LLC may also release information from my medical records to any person or organization liable for all or part of my charges, such as my insurance carrier, any third-party payer, workers' compensation carrier or my employer who is providing payment due to injury on the job. I have received notice that C-U Eyecare, LLC abides by HIPPA privacy policy.

   - Vision care plans only cover routine vision exams along with eyeglasses and contact lenses. Vision plans only cover basic screening for eye disease. They do not cover diagnosis, management or treatment of eye diseases.

   - Medical insurance must be used if you have any eye health problem or systemic health problem that has ocular complications. Your doctor will determine if these conditions apply to you, but some are determined by your case history.

   - If you have both types of insurance plans, it may be necessary for us to bill some services to one plan and other services to the other. We will use coordination of both benefits to do this properly and minimize your out-of-pocket expense.

I authorize C-U Eyecare, LLC to release my personal health information to the following individuals:

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Our office may use emails to communicate with you. Although HIPAA compliant, they may not be encrypted and complete privacy cannot be guaranteed.

___ I authorize the use of email.

___ I do not authorize the use of email to communicate with me.

By signing below, I give consent to C-U Eyecare, LLC to file my insurance. I agree to pay all costs incurred that my insurance does not cover. I have read and understood this form.

Signature ____

Date____

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form (i.e. legal guardian, power of attorney, etc.)

Relationship to Patient____

Print Name____

Source of Authority ____