LAKE EYE ASSOCIATES

A US EYE COMPANY

FINANCIAL AGREEMENT AND ASSIGNMENT OF BENEFITS

Central Florida Premier Eye Associates, P.A. d/b/a Lake Eye Associates (LEA) are privately-owned medical facilities that provide medical services on a fee-for-service basis. LEA relies solely on insurance reimbursement and patient payment(s) for services rendered in good faith. LEA receives no federal, state or other third-party funding; as such, LEA 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.

For the convenience of our patients, LEA participates with most medical insurance companies and vision plans. LEA will submit claims for all medically necessary services to your insurance company. Please note that payment is ultimately due from you if your insurance company denies payment for any service(s); i.e. termination of coverage, coordination of benefits, non-payment of premium, non-participating status, etc. If we do not participate with your medical or vision insurance(s), we will provide you with an itemized receipt so that you may file with your insurance company for any out-of-network benefits to which you may be entitled.

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 LEA 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 LEA 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 LEA 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) LEA 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 (i.e., cosmetic or other services determined by your health insurance plan to be "not medically necessary", etc.), LEA 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).

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

LEA 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, LEA accepts cash, check, money order and credit cards. A 3% convenience fee will be applied to all credit card transactions. In addition, LEA offers financing options through third party vendors.

No Show/ Appointment Cancellation Policy: This policy is designed to help us serve all patients as effectively as possible.

To keep things running smoothly, appointments are necessary. When appointments are missed or cancelled late, it affects more than just our schedule—it limits the availability of care for other patients who could have used those time slots. These disruptions can lead to delays in healthcare for others.

If you need to cancel your appointment, please let us know at least 24 hours in advance. We understand that emergencies happen, but because missed appointments are becoming more common, we must strictly enforce this policy. Consistent no-shows without timely notice may result in a fee for each missed appointment or possible dismissal from our practice. Late arrivals may need to be rescheduled, and the missed appointment fee may apply. Please keep in mind that this fee is not covered by insurance.

We value your understanding and recognize that medical emergencies can happen unexpectedly. Each case will be reviewed individually.

I understand all the terms defined above; I consent to receiving treatment under the stated terms and I agree to honor all my financial obligations to Central Florida Premier Eye Associates, P.A. d/b/a Lake Eye Associates. I hereby authorize the provider and its employees, agents, and assignees, to contact me via e-mail, text message and to my cellular device.

I hereby assign all medical / surgical benefits to Central Florida Premier Eye Associates, P.A. d/b/a Lake Eye Associates, for services rendered to me by the medical providers contracted under Central Florida Premier Eye Associates, P.A. d/b/a Lake Eye Associates, and request that payment of authorized benefits be made to assignee on my behalf. I authorize release of any medical information as may be required by Medicare and / or my other health insurance company to determine my benefits and issue payment to assignee for related medical claims.

My signature below constitutes my Financial Agreement, Assignment of Benefits, and Lifetime Signature Authorization.

Patient Name Printed	**Patient / POA Signature**	**Date**

Failure to honor your financial obligations to LEA 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.