

## RICHMOND EYE ASSOCIATES, P.C.

BARRY E. ROPER, M.D.

D. ALAN CHANDLER, M.D.

MALCOLM MAGOVERN, M.D.

HAROLD A. BERNSTEIN, M.D.

DAVID M. BOWMAN, M.D.

BRYAN M. BROOKS, M.D.

DONALD W. LUMPKIN, JR., O.D.

### MEDICAL SERVICES CONTRACT

I hereby authorize and consent to medical treatment by Richmond Eye Associates, P.C. for me (or my child). I authorize Richmond Eye Associates, P.C. to release my (or my child's) medical information to my (or my child's) family doctor and to any insurance company, adjuster, attorney, authorized agent working on behalf of Richmond Eye Associates, P.C. or other authorized party.

I understand that I am responsible for payment of all medical treatment rendered to me (or my child) by Richmond Eye Associates, P.C., and I agree to pay all co-payments, deductibles and non-covered services in full at the time of the visit. In the event that I am seen at any time by a Richmond Eye Associates, P.C. physician without a required referral, I understand that I am financially responsible for all charges incurred. A fee of \$30.00 will be charged for all returned checks.

I understand that, as a courtesy to me, Richmond Eye Associates, P.C., will file a claim with my (or my child's) insurance carrier, and I authorize payment directly to Richmond Eye Associates, P.C. for the benefits otherwise payable to me under the terms of my (or my child's) insurance. I understand that I am responsible for maintaining current coverage information to meet filing deadlines and for the payment of any remaining balance after payment from my insurance carrier. In the event that I fail to meet my financial obligations, I agree to pay attorney and/or collection agency fees in the amount of thirty-three and one-third percent (33 1/3%) of the amount due at the time the account is turned over for collection plus court costs and any additional collection fees.

"Refraction" - the determination of the best corrective lenses to be prescribed or a change in your glasses prescription (CPT code 92015) is a separate charge in addition to an eye exam. Most insurance companies consider this to be a "non-covered" or not "medically necessary" service. I understand that I am financially responsible for all services denied by my insurance for these reasons. (Refraction fee is \$35.00 as of 7/1/08).

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**Signature of Patient, or Guarantor if Patient is a Minor or Child**

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**Date**