Signature on File

I certify that the information given by me in applying for insurance and/or Medicare payment is true and correct. I authorize Dr. David I. Jones to act as my agent in helping me obtain payment of my insurance and/or Medicare benefits, and I authorize payment of these benefits directly to Dr. David I. Jones, O.D., on my behalf for any services and materials furnished. I authorize any holder of any medical information about me to release to the Centers for Medicare and Medicaid Services and its agents for any information needed to determine these benefits payable to related services. If I have other health insurance coverage my signature authorizes release of the above medical information to the insurer or agency shown, and authorizes my doctor to act as my agent, as above.

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Lifetime Patient Signature   Date

Accounts are due at time of service, excluding amount due from insurance. I understand I am responsible to pay the deductible amount, co-insurance, or any other charges, whether or not paid by insurance. On accounts past due 30 days, a $20.00 late fee will be assessed. Another $20.00 late fee will be assessed for each additional 30-day period your account is past due. After you account is 60+ days past due, your account will be turned over to Express Recovery Services and you'll agree to pay all attorney fees, court costs, filing fees including charges or commission, that may be assessed to us by any collection agency retained to pursue this matter, which may be as much as 50% of the principle balance owing. Returned checks will be directly turned over to Express Recovery Services and will have a $20.00 fee added. The interest rate on past due accounts or returned checks will be 1.5% per month or 18% per year.

Signed: ________________________________ Date: ______________

Acknowledgment of Receipt

I acknowledge that I have been offered a copy of Advanced Family Eyecares notice of privacy policies and practices.

Signature: ________________________________ **Date:** ___________