Geneva Eye Clinic, Ltd.

Self Pay/Private Pay Agreement

Date Completed:_____

This agreement is set forth to accommodate patients with no insurance coverage or for patients that are covered by insurance that Geneva Eye Clinic is not currently contracted with. Self Pay patients will receive a 30% discount on services rendered with the exception of "refraction".

Patient Name: _____

Date of Birth:_____

Address:_____ City: _____State:_____

Telephone:_____ Home/Cell _____

Date of Service:_____

By signing below I agree that:

☐ I have no health insurance coverage at this time

☐ I have insurance coverage that is not contracted with Geneva Eye Clinic, Ltd.

I understand that I am responsible for all charges related to all services rendered to me. A deposit of $75.00 will be due at the time of check in for each visit. Payment in full, minus the deposit, will be due at the time of check out.

If at any time I gain insurance coverage, change insurance carriers, or my contact information changes, it is my responsibility to immediately notify Geneva Eye Clinic, Ltd.

If I have any questions about my charges, statements, or balance due, I will contact the billing department at 630-313-1228.

Patient /Guardian

Signature:_____

Relationship:_____

Geneva Eye Clinic, Ltd. is a participating provider with Medicare and Medicaid carriers and any contractual self-pay agreement is within the reimbursement rate set forth by these institutions.

2/2016