FLORIDA EYE INSTITUTE

Life is Looking Better Already

FINANCIAL POLICY

We are pleased to have you as our patient, and we are committed to providing you with our best professional care. Your understanding of our Financial Policy is important to our relationship. Please ask us if you have any questions.

INSURANCE

Due to all the various insurance plans now in effect, we require that you check with your insurance carrier(s) regarding our participation in your specific network. There are instances when even though we are contracted with a carrier, the carrier has networks in which we do not participate. If our offices does not participate in your network, you will be responsible for a large portion of or the entire bill. The carrier contract information is located on the back of your insurance card. It is your responsibility to update us with any new card that you receive from your carrier. Some insurance plans require an authorization for services in our office. It is your responsibility to acquire the appropriate paperwork. If the visit is not authorized, you will be responsible for the cost of services. We will send your insurance carriers(s) a claim for all services provided. You will be billed for any balance due after the carrier settles your claim.

PAYMENT EXPECTATIONS

If you are not covered by insurance, you will be required to pay for your services on the date the service is required. All patients are required to pay co-payments, deductibles and co-insurance at the time of your visit. You will receive a statement from our office after your insurance has settled your claim if there is any balance due. Payments are expected within thirty dates of receipt of the statement. Our office accepts cash, checks and VISA/MasterCard/Discover.

FLORIDA EYE INSTITUTE

Life is Looking Better Already

PATIENT AUTHORIZATION

I hereby authorize that payment from my medical insurance program or my Medicare benefits be made directly to Florida Eye Institute, PA and Florida Eye Institute Surgicenter, LLC for any unpaid bills for services provided to me on or after today. I understand that I will be financially responsible for any balance not covered by my insurance carrier.

I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

This assignment shall remain in effect until revoked by me in writing. A photocopy of this assignment is considered as valid as the original.

There will be a $25.00 charge for any returned checks.
There will be a $35.00 charge for any account having to be placed with a collection agency.

I have read and understand this policy.

_____ _____

Signature Date

2750 Indian River Blvd., Vero Beach, FL 32960 • 772.569.9500 • 800.423.7703 • Fax 772.569.9507 • www.fleye.com

FLORIDA EYE INSTITUTE

Life is Looking Better Already

PATIENT INSURANCE BENEFIT ESTIMATE

NAME: _____ ACCT#: _____

PA BENEFITS

Cost of Surgery $ _____

$ _____

Patient Responsibility $ _____

Estimated* $ _____

Per Eye ☐ Both Eyes ☐

Omidria: _____

DSAEK: _____

Bio Tissue: _____

Referral YES ☐ NO ☐

Authorization YES ☐ NO ☐

FAC BENEFITS

Cost of Surgery $ _____

$ _____

Patient Responsibility $ _____

Estimated* $ _____

Per Eye ☐ Both Eyes ☐

Referral YES ☐ NO ☐

Authorization YES ☐ NO ☐

***** The above is an **ESTIMATE** of your out of pocket costs for physician and surgery facility fees. Patients are responsible for all copays and deductibles based on **PATIENT INSURANCE BENEFITS** in effect on the date services are rendered.

** Anesthesia will be billed separately.

Patient Signature: _____ Date: _____

Benefits Completed by: _____ Date: _____

2750 Indian River Blvd., Vero Beach, FL 32960 • 772.569.9500 • 800.423.7703 • Fax 772.569.9507 • www.fleye.com

FLORIDA EYE INSTITUTE

Life is Looking Better Already

Credit Card Authorization
Monthly Payment Plan Agreement

Patient Name:_____ Account Number:_____

Name on Credit Card:_____ Billing Zip Code:_____

Credit Card Type:_____ CCV:_____ Exp Date:_____

Credit Card Number:_____

Card Holder's Address:_____

Card Holder's Phone: _____

Monthly Payments	Bill my credit card monthly for payment on my Florida Eye Institute account in the amount of	Estimated Balance*
_____	$ _____	$ _____

First Payment Date	Monthly Payment Date

***Final Balance is provided for estimated purposes only. Applicant agrees that final balance may vary due to patient insurance reimbursement and co-pay policies at time of service.**

Applicant agrees that all personal information provided is accurate and complete. The patient listed above is ultimately responsible for payments whether or not they are the card holder. Applicant acknowledges that if any charges are declined or charge backs are claimed against any outstanding invoiced amounts, extra charges may apply. Disputes to the agreed amount or any/changes in credit card information should immediately be discussed with the billing department at Florida Eye Institute.

Patient Signature:_____ Date:_____

Card Holder's Signature:_____ Date:_____

Florida Eye Institute Representative:_____ Date:_____

PROMISSORY NOTE LOAN AGREEMENT & TRUTH-IN-LENDING ACT DISCLOSURE STATEMENT

This Promissory Note Loan Agreement & Truth-in-Lending Act Disclosure Statement (referred to herein as the "Agreement") is entered into between Borrower (referred to herein as "Borrower", "you" or "your") and Florida Eye Institute (referred to herein as "Lender").

Lender: **Florida Eye Institute**
2750 Indian River Blvd
Vero Beach, FL 32960

Borrower: _____
_____
_____

Date of Loan: _____

Acct Number_____

Social Security #_____

ANNUAL PERCENTAGE RATE 0.00 % The cost of your credit as a yearly rate.	**FINANCE CHARGE $ 0.00** The dollar amount the credit will cost you.	**AMOUNT FINANCED $_____** The amount of credit provided to you or on your behalf.	**TOTAL OF PAYMENTS ESTIMATE $_____** The amount you will have paid after making all scheduled payments (may vary based on insurance reimbursement.)

PAYMENT SCHEDULE: _____ Payments of $_____ are due starting on this date_____

SECURITY: Down payment amount $_____
LATE PAYMENT: does not apply
PREPAYMENT: If you pay off your loan early, you will not have to pay a penalty.

PROMISSORY NOTE

Services Financed:

PROMISE TO PAY: You promise to pay the Florida Eye Institute as per this agreement. You certify and acknowledge that you have received service from our organization and that all the costs were clearly disclosed to you.

SECURITY. You have provided down payment towards your repayment obligation in the form of (a) your personal check and/or (b) your ACH debit authorization in this Agreement, and/or (c) Credit/Debit Card payment YOU agree to PERSONALLY GUARANTEE the Florida Eye Institute for the total of payments amount with no limitations on your liability.

DEFAULT, LATE FEE, AND RETURNED ITEM FEE: You will be in default under this Agreement if (1) you do not pay us what you owe us under this Agreement on or before the payment date. ANY Past due amounts shall bear interest from date of EXECUTION until paid at the rate of **18.00%** per annum. If your payment is in default for 10 or more days, you will owe us a late fee of the greater of 5% of the payment amount (on the principal and interest only) or $7.50. If your check, ACH debit, electronic check, or other payment device which you give to us as payment under this Agreement is returned for any reason, you will owe us a returned item fee of $30.00 (or the State Allowed Returned Item Fee, whichever is greater), plus any applicable taxes. You authorize us, our agents, and our successors and assigns, to collect via ACH debit entry to your account, electronic presentment of your check or any other lawful means all amounts you owe us under this Agreement. For inquires please call Florida Eye Institute @ 772 569 9500.

REMEDIES. You waive notice of default, presentment, and any other notices. Upon default, we shall have the right, without prejudice to our option to exercise any other right, to: (i) deposit your Personal Check; (ii) initiate an ACH debit entry to your checking account for the unpaid principal and accrued unpaid interest; (iii) re-initiate a debit entry for the same amount if your Personal Check or the ACH is dishonored; (iv) draft under the LOC, and/or (v) exercise any other remedies at law or in equity. IF in DEFAULT, you agree to reimburse any/all collections costs, inclusive of THIRD party collections agency, legal fees, court costs, and to cover the administrative costs of organization and collection of the debt. Furthermore, you understand and AGREE that going into a DEFAULT, you will be charged an interest rate of 18% from the DATE of original execution of the contract.

ASSIGNMENT: We may assign or transfer any or all of our rights, title and interest under this Agreement at our discretion. You may not assign or transfer your rights under this Agreement without our prior written consent. REPORTING TO CREDIT BUREAUS: We may report information concerning your account and/or transactions with us to credit bureaus. Late payments, missed payments, or

other defaults on your account may be reflected in your credit report. GOVERNING LAW: This Loan Disclosure and Promissory Note will be governed by the laws of the State of FLORIDA,, except that the Waiver of Jury Trial And Arbitration Provision is governed by the Federal Arbitration Act.

AGREEMENT CONSTRUCTION: If any provision of this Agreement is determined to be valid or unenforceable, such provision shall be reformed if practicable so as to achieve its intended purpose(s) and shall not in any way affect the remaining provisions.

TELEPHONE CALLS - MONITORING: You agree that you will accept calls from us, and/or agents regarding payment reminders and/or the collection of your account. You understand these calls could be automatically dialed and a recorded message may be played. You agree such calls will not be unsolicited calls for purposes of state and federal law. You also agree that, from time to time, we may monitor telephone conversations between you and us to assure the quality of our customer service.

JURISDICTION AND VENUE: This agreement is executed and based in INDIAN RIVER COUNTY FLORIDA. Any/all disputes are to be resolved in the COUNTY Court HERE.

WAIVER OF JURY TRIAL AND ARBITRATION PROVISION: Arbitration is a process in which persons with a dispute: (a) waive their rights to file a lawsuit and proceed in court and to have a jury trial to resolve their disputes; and (b) agree, instead, to submit their disputes to a neutral third person (an "arbitrator") for a decision. Each party to the dispute has an opportunity to present some evidence to the arbitrator. Pre-arbitration discovery may be limited. Arbitration proceedings are private and less formal than court trials. The arbitrator will issue a final and binding decision resolving the dispute, which may be enforced as a court judgment. A court rarely overturns an arbitrator's decision.

THEREFORE, YOU ACKNOWLEDGE AND AGREE AS FOLLOWS:

1. For purposes of this Waiver of Jury Trial and Arbitration Provision (hereinafter the "Arbitration Provision"), the words "dispute" and "disputes" are given the broadest possible meaning and include, without limitation (a) all claims, disputes, or controversies arising from or relating directly or indirectly to the signing of this Arbitration Provision, the validity and scope of this Arbitration Provision and any claim or attempt to set aside this Arbitration Provision; (b) all federal or state law claims, disputes or controversies, arising from or relating directly or indirectly to this Loan Disclosure and Promissory Note (including the Arbitration Provision), the information you gave us before entering into this Loan Disclosure and Promissory Note, and/or any past and/or future claims or disputes between you and us and/or between you and the CSO; (c) all counterclaims, cross-claims and third party claims; (d) all common law claims, based upon contract, tort, fraud, or other intentional torts; (e) all claims based upon a violation of any state or federal constitution, statute or regulation; (f) all claims asserted by us against you, including claims for money damages to collect any sum we claim you owe us; (g) all claims asserted by you individually against us, and/or either of our employees, agents, directors, officers, shareholders, managers, members, parent company or affiliated entities (hereinafter collectively referred to as "related third parties"), including claims for money damages and/or equitable or injunctive relief; (h) all claims asserted on your behalf by another person; (i) all claims asserted by you as a private attorney general, as a representative and member of a class of persons, or in any other representative capacity, against us and/or related third parties (hereinafter referred to as "Representative Claims"); and/or (j) all claims arising from or relating directly or indirectly to the disclosure by us or related third parties of any non-public personal information about you.
2. You acknowledge and agree that by entering into this Arbitration Provision:

a. YOU ARE GIVING UP YOUR RIGHT TO HAVE A TRIAL BY JURY TO RESOLVE ANY DISPUTE ALLEGED AGAINST US, THE CSO AND/OR OUR/ITS RELATED THIRD PARTIES;

b. YOU ARE GIVING UP YOUR RIGHT TO HAVE A COURT, OTHER THAN A SMALL CLAIMS TRIBUNAL, RESOLVE ANY DISPUTE ALLEGED AGAINST US, AND/OR OUR/ITS RELATED THIRD PARTIES; and

YOU ARE GIVING UP YOUR RIGHT TO SERVE AS A REPRESENTATIVE, AS A PRIVATE ATTORNEY GENERAL, OR IN ANY OTHER REPRESENTATIVE CAPACITY, OR TO PARTICIPATE AS A MEMBER OF A CLASS OF CLAIMANTS, IN ANY LAWSUIT FILED AGAINST US, AND/OR OUR/ITS RELATED THIRD PARTIES. YOUR DISPUTE MAY NOT BE CONSOLIDATED WITH THE DISPUTE OF ANY OTHER PERSON(S) FOR ANY PURPOSE(S).

This Agreement is received, executed on this date:_____

FLORIDA EYE INSTITUTE	**BORROWER**
_____	_____
Print	Print
_____	_____
Signature	Signature