**Orangeburg Eye Center, LLC**
**1190 Summers Ave**
**Orangeburg, SC 29115**
**Phone: (803)534-0266**
**Fax: (803)534-0904**
**www.orangeburgeye.com**

# Financial Agreement

**Name:** **Date:**
**Date of Birth:**

**Fees**
Fees at Orangeburg Eye Center, LLC are based on the length and type of treatment. You will be responsible for the charges not covered. Fees are available upon request.
A No Show fee of $25.00 will be charged for any missed appointments not cancelled within 24 hours.

**Methods of Payment**
Methods of payment include cash, credit card, and checks. I understand I am responsible, at the time of service, for my copay and the refraction fee of $30.00, which is not covered by my insurance company.

**Insurance**
Health insurance is a contract between you and your insurance company. I understand there is no guarantee of payment from any insurance company or other payer. I agree to pay all charges for the services provided by Orangeburg Eye Center, LLC which are not paid by my health insurance or other payer. If payment is not made within 90 days from the date the bill was mailed from Orangeburg Eye Center, LLC, I understand that my account will be sent to RMC collection agency. I agree to pay all reasonable legal expenses necessary for the collection of any debt. I understand that any credit or refund that I may be owed will be forwarded to the address on file with Orangeburg Eye Center, LLC.

**Pre-Authorization Requirements**
I accept the responsibility to obtain all referrals or pre-authorizations and to comply with all requirements of any insurance or medical coverage plan upon which I am relying for medical coverage of Orangeburg Eye Center, LLC charges.

**Assignment for Direct Payment**
I authorize that payment of any insurance (including auto insurance and health-care insurance) benefits for health care services or goods may be made directly to Orangeburg Eye Center, LLC.

**Returned Checks**
A $25 service charge will be charged to your account for a check returned for insufficient funds. Orangeburg Eye Center, LLC will require cash or credit card payment if a check is returned.

**I am financially responsible for this account with Orangeburg Eye Center, LLC and agree to the above terms.**

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| Signature of Patient or Legally Responsible Person | Name (Please print) |
| Relationship/Reason Why Patient Is Unable to Sign | Date |
| Witness | Date |