GASKINS EYE CARE & SURGERY CENTER
2335 9TH ST. NORTH SUITE 304
NAPLES, FLORIDA 34103
PHONE: (239) 263-7750
FAX: (239) 263-1754

FINANCIAL AGREEMENT

I hereby authorize any benefits due me under my insurance policy to be paid in accordance with this consignment. In consideration of surgery center, medical and/or anesthesiology services rendered (me) (my dependent), as listed above on the above date, I hereby assign and transfer any benefits due me under the above described contract as follow insofar as they are necessary to cover the expense:

A photocopy of this assignment shall be considered effective and valid as the original.

FINANCIAL AGREEMENT

- In consideration of the services to be rendered to me, I HEREBY INDIVIDUALLY OBLIGATE MYSELF TO PAY THE ACCOUNT IN ACCORDANCE WITH THE REGULAR RATES AND TERMS. Should the account be referred to an attorney or licensed collection agency for collection, I shall pay reasonable attorney's fees and collection expenses. All delinquent accounts (those not paid within 60 days from the date of service) shall bear interest at the legal rate.
- I hereby authorize direct payment of any insurance benefits otherwise payable to me for this admission at a rate not to exceed the regular charges. It is agreed that payment pursuant to this authorization, by an insurance company shall discharge said insurance company of any and all obligations under a policy to the extent of such payment. I understand that I am financially responsible for the charges not covered by this assignment.
- I understand that, as a courtesy, the Center will file my secondary insurance. After 60 days from the date of surgery, the total balance will be considered due and payable.
- I hereby authorize my insurer to assign and transfer any and all applicable plan or policy benefits and rights to the Center and any appointed business associates working with them for the sole purpose of making sure all protected rights and benefits under my plan are administered accurately, including the right to all remedies, disclosures, rights of appeal, administrative reviews and litigation on my behalf. This authorization includes any and all other rights permissible under state and/or federal regulatory guidelines that I, having the right and authority, designate payment to be made and mailed directly to the provider listed above for all services rendered.
- Should I receive a check from any insurance company I used at the time of surgery, I will send such check/s to the Center to be applied to my outstanding balance.

I understand that the Center shall have the right at any time to refuse to admit me or to provide medical care or treatment for me.
I certify that I am the patient or am duly authorized by the patient as patient's general agent to execute this document and accept its terms.

Signed:	Date: (date)	Witness: