



Lake Stevens Vision Clinic, Inc.

LIFETIME AUTHORIZATION FOR:

Print Patient Name

I request that payment of all medical benefits to be made on my behalf to Lake Stevens Vision Clinic, Inc. for all services and materials furnished to me by the Physician's at Lake Stevens Vision Clinic, Inc.

I fully understand that I am obligated to pay any portion of the office fees that are not covered by my insurance company.

I fully understand that information obtained from my insurance carrier on my behalf, relating to medical or vision care benefits, by the staff at Lake Stevens Vision Clinic, Inc. is not a guarantee of payment or a guarantee of actual benefits to be paid or allowed by my insurance carrier.

If, after 60 days of the initial insurance billing, all account balances owed by myself, any of my dependents, or any insurance carrier to the Lake Stevens Vision Clinic, Inc. have not been paid in full, for whatever reason, I agree to pay those past due amounts in full.

In the event of forced collection, I agree to pay all costs of collection, including court costs and all attorney fees. In consideration of any deferred payment due to forced collection, I agree to pay a monthly service fee of 1.0% of the current balance due (APR of 12%), with a \$5.00 minimum monthly service fee.

I have read and fully understand the above office policy of the Lake Stevens Vision Clinic, Inc., and by signing below accept all terms and conditions of that office policy.

SIGNATURE

DATE

515 SR 9 NE, Suite 104
Lake Stevens, Washington 98258
(425) 334-4016 Fax (425) 334-4017