STEVE H. CHANG, M.D.
CATARACT AND REFRACTIVE SURGERY
JAMISON J. ENGLE, M.D.
CORNEA, CATARACT AND REFRACTIVE SURGERY
CALEB K. MORRIS, M.D.
CORNEA AND CATARACT SURGERY
DAN LYONS, O.D., F.A.A.O.
CLINIC DIRECTOR
RYAN DIMIT, O.D.

FINANCIAL INFORMATION

I understand that I, as a patient, am fully responsible for payment on my account with Nevada Eye Consultants, regardless of any insurance coverage. All professional services rendered are charged to the patient. Necessary forms will be completed to help Nevada Eye Consultants with any billing or insurance changes. I agree to pay all attorney fees and/or collection fees, should collection become necessary.

RELEASE OF INFORMATION

I authorize the release of any information regarding the course of my examination and treatment to the insurance companies listed, and/or any physicians I may see. I further authorize Nevada Eye Consultants to obtain medical information from any source deemed necessary for my treatment. A copy of this authorization shall be considered as effective and valid as the original.

ASSIGNMENT OF BENEFITS

I authorize and assign any payment directly to Nevada Eye Consultants. I further authorize to them, any surgical and/or medical benefits ortherwise payable to me for services. My consent is granted to use this original or a copy as effective and valid as the original.

CONSENT FOR ELECTRONIC COMMUNICATION

By providing my email address and/or mobile number, I consent to receive communication through these channels. I understand that I may withdraw consent at any time by notifying Nevada Eye Consultants in writing.

I have read the above financial agreement, release of information, and assignment of benefits, consent for electronic communication and agree to the terms mentioned,I do hereby sign my name.

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Patient Signature Date