ST CLOUD CENTER FOR OPHTHALMIC SURGERY

2055 North 15th St, Ste B
St. Cloud, MN 56303

Financial Agreement

If you have insurance, we will help you receive maximum benefits by filing for you, however, we will expect payment of co-pays, co-insurance and deductibles at the time of service. We can accept cash, personal check, MasterCard and VISA as a means of payment.

Assignment of Insurance Benefits

I hereby request and assign payment of authorized insurance benefits be made on my behalf to St Cloud Center for Ophthalmic Surgery for services rendered to me.

I understand and agree to be financially responsible for charges not paid for within a reasonable period of time by insurance or other third party payer and certify that the information given with regard to insurance coverage is true and accurate to the best of my knowledge.

Release of Information

I authorize St Cloud Center for Ophthalmic Surgery to release all or part of my medical records when required for the submission of any insurance claims to determine benefits and make payment, including the Centers for Medicare and Medicaid Services, for services rendered by St Cloud Center for Ophthalmic Surgery.

The St Cloud Center for Ophthalmic Surgery, it's agents, servants, and employees who render services to me are hereby released from any and all liability of any nature that may arise from the release of such information.

Disclosure Agreement

I have been informed that the physician who is rendering services to me may have an ownership interest in St Cloud Center for Ophthalmic Surgery. I have been given the option to be treated at another facility, which I have declined. I choose to be treated at St Cloud Center for Ophthalmic Surgery.

Certificate

I certify by my signature below that I have read the foregoing or that the foregoing has been read to me, and that I understand completely and accept fully the terms specified therein. I permit a copy of this authorization to be used in place of the original. I have reviewed the center's Payment Policy/Billing Procedures.

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Patient Name (Print)

____ ______________
Patient / Guarantor Signature Date