My signature below states the following:

- ✓ *I understand that payment for this exam fee is always my responsibility. Dr. Hogue and I agree to send a claim for payment into my insurance (a third party).*

- ✓ *I understand that Dr. Hogue will collect my Co-Payment plus any non-covered procedure fees today. He agrees to wait for payment from my insurance company as typically expected they usually will pay claims for my type of service (if you have insurance and the insurance is valid for Vision Care or Medical Eye Care).*

- ✓ *I understand that I can opt out of insurance coverage for my exam services and save 30% on my exam bill as fully billed (No other discounted coupons or gift certificates may apply to the 30% discount (This also does not apply to glasses, exam only)).*

- ✓ *I understand that if I have a Co-Payment amount that I will be paying this amount today (on examination date). I understand that the Co-Payment is **not** the total amount that is billed to the insurance company.*

- ✓ *I understand that I have rights of privacy through a law known as HIPAA. This law does not allow Dr. Hogue or any of his associates who have access to my file to divulge my insurance numbers, telephone numbers, or any personal information related to my financial privacy nor my health privacy. The exception is when I am referred to another trusted specialist (i.e.; cataract/laser or other specialty doctor). I understand that this information is used to obtain payment from my insurance company.*

I agree to the examination and any treatment today based on a standard eye exam that matches my level of need. If the Doctor feels that my visual health is at risk of the type of exam I need (Medical or Refractive) and the likelihood of an insurance benefit payment for my condition.

*Name:*____

*Signature*______________________________*Date:*___________________