James E. Davis Jr. O.D.

3411 N. Woodford St.
Decatur, IL 62526
Phone: 217-877-0312

Agreement for payment of the following service(s)/product(s)

Exam $_____
Frame $_____
Lenses $_____
Contact Evaluation $_____
Contacts $_____
Insurance Exam co-pay $_____
Insurance Material co-pay $_____
TOTAL AMOUNT DUE $_____

Acceptance Agreement

The above price, specifications, and conditions are satisfactory and are hereby accepted. If payment is not made in the agreed amount of time for the balance, **Dr. Davis** reserves the right to turn it over to a collection agency and/or attorney. I understand that I am then responsible for all the fees necessary for the collection of the delinquent account including, but not limited to, collection agency fee of 50% of the balance due and costs and reasonable attorney's fee of 33% of the balance.

Certification and Assignment

I certify that I and/or my dependant(s), have insurance coverage with _____
Name of Insurance Company
and assign directly to **Dr. Davis** all insurance benefits, of any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I authorize the use of my signature on all insurance submissions.

Dr. Davis may use my health care information and may disclose such information to the above named Insurance Company and their agents for the purpose of obtaining payment for the services and determining insurance benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform **Dr. Davis** if I, or my minor child, ever have a change in health.

_____ _____
Print Name of Patient, Parent, Guardian or Personal Representative Date

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Relationship to Patient