ASSOCIATED EYE CARE, INC.

2702 Navarre Ave.
Suite 205
Oregon, OH 43616
(419) 696-7780
(419) 696-7782 fax

1000 Regency Ct.
Suite 100
Toledo, OH 43623
(419) 882-0588
(419) 885-3070 fax

960 W. Wooster St.
Suite 216
Bowling Green, OH 43402
(419) 352-5500
(419) 352-5577

SELF PAYMENT

I understand that the service(s) provided to me today are my responsibility. Payment is required at the time of service.

If full payment is not possible, I am willing to set up monthly payment arrangements with the Billing Department. Also, I understand that I am expected to make a substantial payment toward the charge(s) today.

In addition, if I am unable to provide correct insurance information at the time of service that is also considered as a Self Pay appointment. In that case, I am responsible for payment as above or may reschedule the appointment until I am able to provide the correct insurance information.

Patient's Name _____ Date _____

Signature of patient or legal guardian _____

Signature of witness _____ Date _____

K. Charles Raffoul, M.D. Christina P. Tam, M.D. James A. Knupp, M.D. Anjali Tapadia, M.D.
Dino J. Costa, O.D. Carol J. German, O.D. John M. Elchinger, O.D.