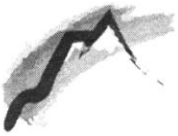

Summit Eye Consultants

Jacqueline Wong, MD
945 Hildebrand Lane, Suite 235
Bainbridge, WA 98110
Phone: (206) 201-3669
Fax: (206) 451-4890

Financial Agreement

I, the undersigned, authorize **Summit Eye Consultants** to disclose information provided by me to my insurance company for medical services. If co-pays and/or deductibles are designated by my insurance company or health plan, I agree to pay them to **Summit Eye Consultants**. In the case that my insurance does not deem medical care has met plan coverage rules and does not pay for some or all services provided during my visit, or in the case that there is no insurance(s) available to be billed, I agree in return for the services provided by **Summit Eye Consultants**, I will pay my account at the time services are rendered or will set up financial payment plans with **Summit Eye Consultants**. In the circumstance that either insurance is available or I elect to pay for the services personally, and the account is sent to an attorney for collection, I agree to pay collection expenses and reasonable attorney fees as established by the court and not by a jury in any court action. I understand and agree that if my account is delinquent, I may be charged interest at the legal rate. Any benefits of any type under any policy of insurance insuring the patient or any other party liable to the patient is hereby assigned to **Summit Eye Consultants**. However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of the respective bill.

Patient Signature:_____ Date:_____

Parent/Guardian Signature:_____