Alaska EyeCare CENTERS

Payment Agreement

Patient Name: _____ Account #:_____

I agree to make payments on my account with Alaska Eye Care Centers until the balance due is paid in full. **50% of the total balance due is due at the time of service**. I will make payments on my remaining balance as follows:

☐ I will make monthly payments on my account to begin on the _____

day of _____202____in the amount of $_____.

☐ I will make bi-weekly payments on my account to begin on the _____

day of _____ 202___in the amount of $_____.

☐ I will make weekly payments on my account to begin on the _____

day of _____ 202____in the amount of $_____.

☐ **I will pay my balance in full at the time of delivery of my eyeglasses/contacts. If glasses are not picked up within 30 days, the frame will be returned to stock, and the lenses will be mailed to you. I will be responsible for the lens fees in full.**

The balance due on my account as of today is $_____. I understand that if services (or products) are rendered to me from this date on my balance will increase and that I am responsible for any amount my insurance does not cover.

I understand that if I break my agreement to make payments as promised my account will be turned over to collections and that I will be responsible for any fees associated with the collection of the debt. I understand that if I miss my payments as agreed the balance will be due in full immediately.

By signing this payment agreement, I confirm that I understand and agree to pay the amount due to Alaska Eye Care Centers for services (or products) that I have received.

_____ _____
Signature of Patient/Guarantor Date

_____
Printed name of Patient/Guarantor

_____ _____
Printed Name of Alaska Eye Care Representative Date