Affiliate Physician Practice

Fax completed form to
617 573-6483

MASSACHUSETTS EYE AND EAR INFIRMARY
LASER VISION CORRECTION CENTER
ELECTIVE/COSMETIC SURGERY PAYMENT AGREEMENT

PATIENT NAME: ______________________________ MEEI MR #: ______________

SURGEON: ______________ DATE OF EVAL: ______________ DATE OF SURGERY: ______________

ELECTIVE / COSMETIC PROCEDURE/S: **REFRACTIVE SURGERY WITH PC-IOL LENS REPLACEMENT**

CHARGES FOR ELECTIVE / COSMETIC PROCEDURE/S, PER EYE:

HOSPITAL FEE:	$ 2460.00
ANESTHESIA FEE:	$ 600.00
TOTAL:	**$ 3060.00**

NOTE: Final charges must be paid in full at least 2 weeks prior to surgery. Payment by credit card can be made over the telephone by calling 617-573-4098 or 617-573-3071 between the hours of 9:00 a.m. and 5:00 p.m. Monday through Friday. **Surgeries not paid in full in advance will be rescheduled.**

By your signature below you acknowledge that this surgery is elective and not medically necessary, that you have read and understood the above information and have had all of your questions answered, and that you agree to accept personal responsibility for payment in full of all final charges.

______________________________ ______________________

Signature of patient Date

______________________________ ______________________

Signature legally responsible party other than patient Date

Comments:

Revised: 05/09/06