Collections, Cell Phone and Email Policy

Our office will make two attempts at collecting balances due. If payment in full or payment arrangements have not been made thirty days after our second attempt, your account will be turned over to a collection agency. **MEDICAL RECORDS, PRESCRIPTIONS AND ANY AND ALL FORMS WILL NOT BE RELEASED, COMPLETED, FILLED OR REFILLED UNTIL YOUR ACCOUNT IS RELEASED FROM COLLECTIONS AND HAS A ZERO BALANCE.**

EXPRESS PRIOR TO CONSENT TO CONTACT CONSUMER BY CELL PHONE: You agree, in order for us to service your account or to collect monies you may owe, iCare EyeCare and/or our agents, may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails using any email address you provide to us. Methods of contact may include using pre-recorded/artifical voice messages and/or us of automatic dialing devices, as applicable.

I have read this disclousre and agree that **iCare EyeCare**, its employees and/or agents may contact me as described above.

Signature:_____ Date: _____
(Patient Signature, Parent or Guardian if the patient is a minor)

EXPRESS PRIOR TO CONSENT TO CONTACT CONSUMER BY EMAIL: You agree, in order for us to service your account or to collect monies you may owe, **iCare EyeCare** and/or our agents, may contact you by email at any address associated with your account, including wireless telephone numbers, which could result in charges to you. You will provide us an accurate email address for these purposes.

Signature:_____ Date: _____
(Patient Signature, Parent or Guardian if the patient is a minor)

AGREEMENT TO PAY: I, the undersigned, accept the fee charged as a legal and lawful debt and agree to pay said fee, including any and all costs of collection, (33 1/3%), attorney fees and or court costs if such be necessary. I waive now and forever my right of exemption under the laws of the constitution of the State of Alabama and any other state.

Signature:_____ Date: _____
(Patient Signature, Parent or Guardian if the patient is a minor)