STATEMENT OF FINANCIAL RESPONSIBILITY: Unless otherwise prohibited, I unconditionally guarantee payment in full to Starkville Eye Clinic, its physicians, and other healthcare professionals that may render treatment and services to me.

I hereby authorize and consent to the release of all medical and personal information (including but not limited to my home phone, cell phone, work phone, address and email address) by or to the hospital and by or to any and all healthcare professionals involved in my care; Interpretation of test results; account billing and collections; payment posting and/or processing; or related healthcare functions. This authorization shall remain in effect until such time as all account balances extending from the encounter have been fully satisfied.

I authorize the hospital and all clinical providers who have provided care or interpreted my tests, along with any billing service and their collection agency or attorney who may work on their behalf, to contact me on my cell phone and/or home phone using pre-recorded messages, artificial voice messages, automatic telephone dialing devices or other computer assisted technology, or by electronic mail, text messaging or by any other form of electronic communication.

ASSIGNMENT OF INSURANCE BENEFITS: I hereby assign and authorize and direct payment to SEC or any other healthcare provider of all insurance benefits, including those provided under Medicare and Medicaid under Title XVIII/XIX of the Social Security Act, payable under their respective terms for my services and medical treatment. Unless otherwise provided by law, the filing or processing of any claim shall not be a condition precedent to any collection of any unpaid charges, and shall not be constructed as the assumption of any duty by SEC with regard to the insurance.

To the extent allowed by law, I remain responsible for any portion of the hospital bill not paid by insurance, including co-insurance, denied claims or deductibles; I understand that if a private room is requested or provided, I am responsible for any additional unpaid charges incurred.

RELEASE OF INFORMATION: In addition to that provided above, the hospital and its physicians may disclose all or any part of the patient's record when such disclosure is necessary for my continued treatment, the payment for the services I receive, for healthcare operation or as may be required or allowed by applicable law. For detailed information about how your healthcare information may be used, please review SEC's Notice of Privacy Practices. I permit a copy of these authorizations and assignment to be used in place of the original.

Signature of Patient/Guarantor Date

Signature of Patient Representative/ Spouse and Relation ship Date