



**Affiliate Physician Practice**

Fax completed form to  
617 573-3849

**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 CLEAR LENS REPLACEMENT**

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

HOSPITAL FEE: \$ 1700.00  
ANESTHESIA FEE: \$ 600.00

**TOTAL: \$ 2300.00**

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:  
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