To: Patient Chart

Patient Name: ___________________________

Date: ___________________________________

After discussing the lens options available to me, I have agreed to have an upgraded intraocular cataract lens implanted at St. Mary's General Hospital by

Dr ______________________________________

I understand and acknowledge that I will be responsible to pay the difference between the upgraded lens price and the regular lens price totaling $ ________________. I understand that payment of the outstanding balance is required before my surgery is performed.

Lens Requested	Patient Payment	Physician to check the lens discussed (√))
Toric Lens	**$560**	
Restor Lens	**$1,000**	
Tetraflex Lens	**$1,300**	
Crystalens 5.0	**$900**	
Crystalens HD	**$1,100**	
Crystalens AO	**$1,000**	

Payment by cash, cheque or Visa / Mastercard will be accepted.
Payment can be made at the finance department located on the 3rd floor of the Gordon MacKay Administration Building. Contact (519)-749-6660 for further instructions. A receipt will be provided and attached to this agreement. I understand I am to bring this agreement to the hospital on the day of surgery, with proof of payment, and give to the day surgery registration clerk.
Payment can also be made by the patient going online, at least 2 business days prior to the date of your surgery, at www.smgh.ca select "Bill Payment" on the far left of the page, pick online payment and for account number enter "contact lens". With the other information required on that form, we will update your account and notify the OR / the day surgery registration clerk of payment.

Patient Signature: ____________________________ Date: __________________________

Physician Signature: ___________________________Date: _________________________

Price list effective April 2010