



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	\$ 560.00	
Restor Lens	\$ 1000.00	
Tetraflex	\$1,300.00	
Crystalens Five-O	\$ 735.00	

This upgraded lens agreement and payment must be brought to the cashier's office at St. Mary's General Hospital (located in the front lobby) prior to the day of surgery. Payment by cash, cheque or Visa will be accepted. The Finance office is open weekdays between the hours of 8:00am – 4:00pm. Payment can also be made using VISA by calling the Patient Accounts office at SMGH at (519)-749-6660. 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 and give to the day surgery registration clerk.

Patient Signature: _____ **Date:** _____

Physician Signature: _____ **Date:** _____