10363 Democracy Lane,
Fairfax Virginia, 22030
Eyegaze Inc. U.S.A
Phone: 703-385-8800

Financial Responsibility Form

Name of User (print): ____ Social Security #______________________

Health Insurance Disclaimer:
"A quote of benefits and/or authorization does not guarantee payment or verify eligibility. Payments of benefits are subjected to all terms, conditions, limitations, and exclusions of the member's contract at the time of service."

Health Insurance Liability for Payment:
Your health insurance company will determine the services covered and amount depending upon your plan benefits. Eyegaze Inc. will contact your insurance company to request this information and provide you with the best estimate of out of pocket expense based on the information provided. (Please refer to the Health Insurance Disclaimer above.) Eyegaze Inc. does not receive any guarantees or commitment for payment from the insurance company. Our device is considered durable medical equipment. Please contact your insurance company to find out your benefit levels, exclusions, and/or plan limitations. We encourage clients to know their plan benefits.

Beneficiary Agreement:
Exact insurance benefits often cannot be determined. Until the receipt and processing of the claim, exact payment amounts and percentages are estimates. The decision to move forward with purchasing Eyegaze Inc.'s device is NOT conditional upon receiving insurance payment. As a courtesy to our patient's, we work with the insurance companies, on our client's behalf, to collect available benefits and maximum payment when purchasing an Eyegaze Edge. In some cases, there is not enough information provided by the insurance company to determine an accurate out of pocket expense, and the client maybe requested to submit payment in full prior to delivery, In this situation, Eyegaze Inc. will submit the claim for processing and direct payment to you. The same amount of dedication and effort will be made to collect all available benefits and maximum payment.

I understand that my health insurance company may deny payment for service. I also understand that if my health insurance company does make payment for services, I will be responsible for any co-payment, deductible, coinsurance and remaining balance after said payment that applies. I agree to be personally and fully responsible for any balance amount due for the purchasing the Eyegaze Edge. It is my responsibility to notify Eyegaze Inc. of any changes in my health care coverage.

By signing this document, I am accepting financial responsibility as explained above for all payments for products received. I request that payment of authorized insurance benefits be made on my behalf to Eyegaze Inc. listed below.

Eyegaze Inc.
10363 Democracy Lane
Fairfax, Virginia 22030

Printed Name of Insured or Parent/Guardian: ____

Signature of Insured or Parent/Guardian: ____

Date: ____

For questions regarding funding for the Eyegaze Edge, please call us at 703-385-8800.