

## SEI MICHIGAN MANAGEMENT LLC SERVICES AGREEMENT

Please read and sign one of the following agreements:

As a value-added service, I authorize SEI Michigan Management LLC, or an affiliated company to collect pre and post procedure fees on my behalf, and in my name, from each patient for whom I will provide pre and post procedure care for laser vision corrections procedures. When I refer a patient, I will indicate the amount of co-management fee I would like collected on my behalf. I understand and hereby agree to SEI, or an affiliated company deducting a \$12.00/eye administrative fee to collect and to distribute my co-management fees. I understand and agree that SEI, or an affiliated company will forward a check to my attention by the 15<sup>th</sup> day of each month for services provided in the prior month. I have carefully read the enclosed material and certify that all the information I have provided is correct.

SIGNATURE: \_\_\_\_\_

NAME (PRINT): \_\_\_\_\_

DATE: \_\_\_\_\_

SEI Michigan Management, LLC should make my co-management fee checks payable to the following:

Legal Practice Name: \_\_\_\_\_

Office Address: \_\_\_\_\_

City / State: \_\_\_\_\_

Zip / Postal Code: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

Social Security or Federal Tax ID Number: \_\_\_\_\_

### **NO – I do not want to take advantage of this service**

I have carefully read the enclosed material and will continue to collect my own co-management fees for laser vision correction procedures. When I refer a patient, I will indicate that I will collect my own co-management fee.

SIGNATURE: \_\_\_\_\_

NAME (PRINT): \_\_\_\_\_

DATE: \_\_\_\_\_

### **Other Terms and Conditions:**

1. This service agreement may be terminated by written notice from either party.
2. Refunds or adjustments requested by patient with respect to all or a portion of the co-management fee will be advised to contact their co-managing eye doctor directly.
3. Payments to all parties from third party payers will be distributed upon collection and will reflect any reduction on payment from eh TPP, subject to balance billing when possible.

### **Please submit your completed form to:**

Refractive Coordinator  
Specialty Eye Institute  
Fax: (517) 841-0141