LOGAN EYE INSTITUTE

SERVICE AGREEMENT

This Service Agreement is entered into by and between _____ ("Service Provider") and Logan Eye Institute, PLLC (the "Institute") as is dated the _____ day of _____, 2018 (the "Effective Date"). Service Provider is in the business of providing refractive surgery. pre-operative examination, and/or follow-up care services to its patients (the "Services") and

1. By their signatures below, the parties agree that the Institute will bill and collect all fees associated with the performance of any of the Services (including the surgeon's fee, the facility fee, and the fees related to follow-up care) performed by the Service Provider.
2. As Service Provider's sole compensation for providing the Services, Service Provider agrees that he or she shall be paid a co-management fee by the Institute.
3. The parties agree that the CM Fee covers the basic refractive surgery pre-operative eye examination and follow-up visits (1-day, 1-week, 1-month, 3-month, 6-month, 1-year) plus any other refractive surgery-specific follow-up visits which the patient may require (including enhancement follow-up visits up to one year) and that Service Provider shall not be further compensated for any such services.
4. In relation to collection of the CM Fee, Service Provider authorizes the Institute to either (please initial):
   _____ Collect the co-management fee (the "CM Fee") in Service Provider's name and on his or her behalf from each patient for whom Service Provider performs any of the Services. In such case, the Institute will bill and collect the CM Fee at the same time that it bills and collects its professional service fee and its facility fees on its own behalf (the "Institute Fees"). The Institute will forward the CM Fee to Service Provider within twenty (20) days after the Institute has been paid for the Service(s); provided that the parties agree and acknowledge that it may be longer than 20 days if the any of the procedures related to the Services are billed to an insurance company, or if the Institute has not received this completed Service Agreement. If Service Provider selects this option, all checks for the CM Fee should be made payable to:

   _____ (Check one) ____ Corporation ____ Partnership ____ Sole Proprietor
   (Legal name under which you conduct your practice and use for tax purposes - please print clearly)

   _____ _____
   (Street Address) (City) (State) (Zip Code)

   _____ _____ _____
   (Telephone) (Fax) (SSN/Federal EIN)

   _____ _____
   UPIN# NPI#

   or _____ Service Provider will collect his or her own CM Fee for the Services.

5. Service Provider understands and agrees that:
   a. This Service Agreement will continue to be in effect until terminated by either party upon written notice to the other.
   b. Patients requesting refunds or adjustments with respect to all or part of the CM Fee will be advised to address their concerns directly to Service Provider, who will be responsible for handling such matters.
   c. Service Provider confirms that he or she is a duly licensed and insured eye care professional (optometry/ ophthalmology) in good standing in all states in which he or she regularly practices. Service Provider is knowledgeable about refractive surgery and the risks and benefits of such. Service Provider is responsible for the care in which he or she renders to his or her patients. Service Provider maintains professional liability insurance with a reputable insurance company in an amount customary for professional practices similar to Service Provider's practice.
   d. Service Provider agrees to fax or mail a copy of his or her professional license and current professional liability insurance to the Institute at the address given below.
   e. Service Provider agrees to provide the Institute with the pre-operative and post-operative reports (1-day, 1-week, 1-month, 3-month, 6-month, and 1-year) for all follow-up visits with each patient that receives any Services, and will report any adverse events (i.e. infections, haze, intraocular pressure in excess of 25 mm Hg., etc.) in those reports. Each such report shall be sent to the Institute within seven (7) days following each follow up visit.

Please return completed form by fax, mail or email to:
Fax: (435) 787-7200 Attn: Jodi Jones Email: jjones@loganeyeinstitute.com
Mail: Logan Eye Institute, PLLC
Attn: Jodi Jones
810 South 100 West Ste A
Logan, Utah 84321

Should any party herein become aware of any fact that would make any of the information or statements contained in this Agreement change or become untrue at any time, such party agrees to notify the other party in writing within tern (10) days.

INSTITUTE:

By: _____ _____ _____
(Signature and title) (Name Printed Clearly) (Date Signed)

SERVICE PROVIDER:

_____ _____ OD/MD _____
(Signature) (Name Printed Clearly) (Date Signed)