CareCredit Charge Form – Charges Processed Through QualSight. Please Immediately Fax to 773-632-4132.

CREDIT LIMIT:	**1. $**
PRACTICE NAME:	**2.**
SURGERY DATE:	**3.**
PATIENT NAME:	**4.**
CARECREDIT ACCOUNT #:	**5. 6019 - XXXX - XXXX____ NEED LAST FOUR DIGITS ONLY**

6. Please check the box and enter number of eyes and procedure type(s) below:

- ☐ One Eye Traditional LASIK
- ☐ Both Eyes Traditional LASIK
- ☐ One Eye Traditional PRK
- ☐ Both Eyes Traditional PRK
- ☐ One Eye Custom / Wavefront LASIK
- ☐ Both Eyes Custom / Wavefront LASIK
- ☐ One Eye Custom / Wavefront PRK
- ☐ Both Eyes Custom / Wavefront PRK

7. Please enter the total amount to be financed next to Assurance Plan you have chosen

TOTAL AMOUNT FINANCED:

☐ **$_____ - One Year Assurance Plan**
Additional Notes :

☐ **$_____ - Lifetime Assurance Plan**
Additional Notes :

8. PLEASE PICK YOUR PAYMENT PLAN FROM BELOW ***(These are the ONLY plans available through QualSight.)***
IF YOU DO NOT PICK A PLAN, YOUR PAYMENT PLAN WILL BE 24 MONTHS AT 14.9%

☐ No Interest Payment Plan if Paid in Full with 6 Months:

* OR *

☐ 14.90% APR and Fixed Monthly Payments Required Until Paid in Full

Minimum charge $1,000 (14.9% interest rate) ☐ 24 Months ☐ 36 Months ☐ 48 Months

Minimum charge $2,500 (14.9% interest rate) ☐ 60 Months

* Cardholder Accept That Charges will be Processed Through the QualSight Terminal AND that the Patient's Copy will stand as Receipt of Charges.

* Cardholder acknowledges receipt of goods and/or services in the amount of the TOTAL amount financed and agrees to perform the obligations set forth in the Cardholder's Agreement with the Issuer.

* Cardholder acknowledges that the charges are correct as listed.

* Cardholder acknowledges to have read form in it entirety before choosing Assurance Plan and before choosing payment plan.

* Cardholder acknowledges that full refunds will be issued ONLY in the event the procedure is cancelled.

* Cardholder acknowledges that a request to make changes to charges after the procedure is completed is a correction made solely at the discretion of QualSight in agreement with the surgery location.

* Your signature below acknowledges that you have received services from a CareCredit Provider (QualSight, Inc. surgeon and practice). You Hereby agree to perform the obligations set forth in your Cardholder Agreement with GE Capital Retail Bank.

PATIENT SIGNATURE: (X)	**9.**
	Verified by Driver's License, State Issued I.D. or Federal Government I.D.
CARDHOLDER SIGNATURE: (X)	**10.**
	Verified by Driver's License, State Issued I.D. or Federal Government I.D.
CARDHOLDER IDENTIFICATION VERIFIED BY:	**11.**
	Practice Employee Please Print Name

For questions regarding QualSight prices please call (877) 704-2010

For questions regarding your CareCredit account, please call (866) 893-7864

12. Practice, please return by Fax to QualSight – (773) 632-4132

CareCredit Charge Form – Charges Processed Through QualSight, Inc. - Faxed to 1-773-632-4132

Patient's Copy

* Your signature acknowledged that you have received services from a CareCredit Provider (QualSight, Inc. surgeon and practice). You Hereby agree to perform the obligations set forth in your Cardholder Agreement with GE Capital Retail Bank.
* Cardholder acknowledged receipt of goods and/or services in the amount of the TOTAL amount financed and agrees to perform the obligations set
* Cardholder acknowledged that the charges are correct as listed.
* Cardholder acknowledged reading form in it entirety before choosing Assurance Plan and before choosing payment plan.
* Cardholder acknowledged that full refunds will be issued ONLY in the event the procedure is cancelled.
* Cardholder acknowledged that a request to make changes to charges after the procedure is completed is a correction made solely at the discretion of QualSight in agreement with the surgery location.

CREDIT LIMIT:	**1. $**
PRACTICE NAME:	**2.**
SURGERY DATE:	**3.**
PATIENT NAME:	**4.**
CARECREDIT ACCOUNT #:	**5. 6019 - XXXX - XXXX___ NEED LAST FOUR DIGITS ONLY**

6. & 7. **Please enter the total amount to be financed next to Assurance Plan you have chosen**

TOTAL AMOUNT FINANCED:

☐ **$_____ - One Year Assurance Plan**	☐ **$_____ - Lifetime Assurance Plan**
Additional Notes :	Additional Notes :

8. PLEASE PICK YOUR PAYMENT PLAN FROM BELOW ***(These are the ONLY plans available through QualSight.)***

IF YOU DO NOT PICK A PLAN, YOUR PAYMENT PLAN WILL BE 24 MONTHS AT 14.9%

☐ † No Interest Payment Plan if Paid in Full with 6 Months:

* OR *

☐ 14.90% APR and Fixed Monthly Payments Required Until Paid in Full

Minimum charge $1,000 (14.9% interest rate)	☐ 24 Months †	☐ 36 Months	☐ 48 Months
Minimum charge $2,500 (14.9% interest rate)	☐ †60 Months		

No Interest Payment Plan if Paid in Full with 6 Months: (with Payment / Deferred Interest)

*NOT ALL PROMOTIONAL PERIODS ARE AVAILABLE TO ALL RETAILERS/ MERCHANTS/ DEALERS.

Interest will be assessed if the promotional purchase is paid in full within the 6 month promotional duration (promo period) as stated above. If the promotional purchase is paid in full within the promo period, interest will be imposed from the date of purchase at the Purchase APR Shown on the attached sales receipt or below. Minimum monthly payments are required. Making only the minimum monthly payments required by your monthly statement may not pay off the promotion within the promo period. Regular account terms apply to non-promotional purchases and, after promotion ends, to promotional purchase. If account becomes 60 days past due, promo may be terminated early, accrued interest will be billed and regular account terms apply.

14.90% APR and Fixed Minimum Monthly Payment Required until Paid in Full Extended Payment Plan ("Fixed Payment / Reduced APR")

Interest will be assed on your promotional purchase balance from the purchase date at a 14.90% Promotional APR until paid in full. Fixed monthly payments are required, and will be calculated as follows: on 24 month promo - the fixed monthly payment will be 4.8439% of the initial promo purchase amount; on 36 month promo - 3.4616%; on 48 month promo - 2.7780% of amount; and on 60 month promo - 2.3737% of amount. See above for the number of months used to calculate your fixed monthly payment. The fixed monthly payment may be higher than the minimum payment that would be required if this was a non-promotional purchase. Regular account terms apply to non-promotional purchases and, after promotion ends. to promotional purchases. If account becomes 60 days past due, promo may be terminated early and regular account terms will apply.

This is NOT the Charge Slip. For Patient Information Only.

For questions regarding QualSight prices please call (877) 704-2010

For questions regarding your CareCredit account, please call (866) 893-7864

Practice, please return by Fax to QualSight – (773) 632-4132

QualSight, Inc. CareCredit Form Instructions - Please Print Legible

1. Enter the patients credit limit
2. Enter your Practice Name and Identifier
3. Enter the LASIK Surgery Date
4. Enter the Patient name
5. Enter the patient CareCredit Account number (last four digits needed)
6. Check the box and enter number of eyes and procedure type(s)
7. Enter the total amount financed and if patient selected 1 Year Assurance Plan or Lifetime Assurance Plan
8. Enter the patients payment plan in the available boxes i.e. 6 months interest free or [24, 36, 48 or 60 months with14.9% interest rate]
9. Obtain patient signature and photo copy ID
10. Obtain CareCredit cardholder signature and photo copy ID
11. Confirm cardholder identity
12. Fax completed forms and ID photo copy to QualSight, Inc. at 1-773-632-4132

QualSight, Inc.
945 W. George Street, Suite 201
Chicago, IL 60657
1-877-704-2010
1-773-350-3357 emergency cell phone