I. PROTECTED HEALTH INFORMATION CONSENT, INSURANCE AUTHORIZATION:

I give my consent for protected health information to be created, maintained and used by Kentucky Eye Institute (KEI) for treatment, billing, and/or other health care operations. I give consent to examination and/or treatment by Drs. Ditto, Musick and/or Kroggel. I request that payment of authorized Medicare/Medicaid and/or other insurance benefits be made on my behalf to Drs. Ditto, Musick, Kroggel and/or to KEI for any applicable services or products provided to me. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (CMS) and its agents or other insurance companies, any information needed to determine these benefits or the benefits for related services. I understand that it is my responsibility to obtain appropriate referrals, when necessary, from my primary care physician or health care plans. I understand that I am responsible for payment of services or products, if applicable, for which I did not obtain a valid or timely referral. I acknowledge that I am responsible for payment, at the time of each visit, for all services or products provided by Drs. Ditto, Musick, Kroggel, Jessamine Optical or KEI which are not covered by an assigned insurance or agency or for which no prior payment arrangements has been made.

As a courtesy to our patients, we will file claims with the appropriate insurance companies. We will attempt to verify your eligibility and present an estimate of your financial responsibility; however this is not a guarantee of your health care coverage or payment. Your insurance company makes the final decision regarding eligibility and benefits. It is your responsibility to know your benefits and limitations of your current health care coverage.

II. FINANCIAL RESPONSIBILITY

I agree to pay all reasonable attorney fees and collection costs in the event of non-payment of my charges. This includes any contact lens evaluations performed during the exam.
A finance charge of 1.5% monthly applies to outstanding balances over 90 days, patient due.

III. HIPAA

I acknowledge receipt of the document titles "Notice of Privacy Practices"

IV. Refraction Payment Policy

Refraction is the process of determining the best possible visual acuity and function of your eyes, as well as the need for corrective glasses and/or contacts. Congress has determined that the refraction is NOT a covered service by Medicare; most medical insurance plans follow Medicare guidelines, as well. Our fee for refraction is $40 and will be collected at the time of service in addition to any co-pays or deductibles your insurance plan may require. Should your plan pay us for the refractions, we will reimburse you accordingly.

Print Name:____ Date of Birth:____________________

Signature:____ Date:___________________________

Insurance Information:

______________________________	______________________________
Medical Insurance Plan	Vision Insurance Plan
______________________________	______________________________
Policyholder SS#	Policyholder SS#
______________________________	______________________________
Medical Insurance Policy Holder's Name	Vision Insurance Policy Holder's Name
______________________________	______________________________
Policyholder's Date of Birth	Policyholder's Date of Birth