

BLUEGRASS EYE CENTER

JOHN A. DISTLER, M.D. ANNE C. HUNTINGTON, M.D. B. MATTHEW BLAIR, M.D.
DISEASES AND SURGERY OF THE EYE

ABOUT FINANCIAL ARRANGEMENTS, INSURANCE AND REFERRALS

We are committed to providing you with the best possible eye care. In order to achieve this goal, we need your assistance and your understanding of our payment policy.

Our physicians participate in a number of insurance plans. If we participate with your plan, we will collect any known co-payment, known deductible and non-covered amounts, prior to you being seen by the physician.

If we do not participate with your plan, your charges are due in full at the time of service. We will provide you with an itemized receipt of your services, which you can submit to your insurance company for reimbursement.

It is your responsibility to provide us with correct and current insurance information at the time services are rendered.

Your insurance company may require you obtain a referral from you primary care physician for services rendered by a specialist. If you cannot obtain a referral from your primary care physician prior to your visit, you agree to be responsible for any and all charges that occur.

Your Medical Insurance covers a Medical examination ONLY. A medical exam does NOT include performing refraction. A refraction is the test which determines if your vision can be improved with glasses. In certain situations this test may be necessary for the doctor to make a proper diagnosis. There is a \$25 fee for this test.

We must emphasize that our relationship is with you not your insurance company. All charges are your responsibility. We realize that temporary financial problems may arise time to time. Our patient service representatives are here to help you, and meet your needs; please feel free to discuss your concerns or needs with us. There will be a \$25 charge for all insufficient checks.

Should collection procedures be necessary to obtain payment for your balance, you agree to assume all fees associated with the collections process. Also all attorney/lawyer fees should they become necessary are to be reimbursed by the patient.

I request that payment of authorized insurance benefits be made either to me or to Bluegrass Eye Center for any services rendered. I hereby authorize any holder of medical information to release all information necessary to determine insurance benefits and process such benefits for payments.

Notice: Due to constantly changing insurance regulations, benefits, deductibles, co-pays, etc., we are only able to approximate your balance. Final responsibility for payment rests with the patient.

For our optical/contact lens patients...a 50% deposit is required at the time you are fitted for the glasses/lenses and the order is placed. The remaining balance on the glasses/lenses is due at the time the glasses/lenses are dispensed.

Date

Signature of guarantor/patient

Date

Signature of guarantor/patient

Date

Signature of guarantor/patient