PLEASE READ THIS FORM CAREFULLY

I consent to medical care and treatments.

I authorize the release of all medical records to my physicians and insurance company. I also authorize fax transmittal of my medical records to my physicians and insurance company.

It is your responsibility to know your individual coverage. If your insurance company requires a referral form and you do not obtain one, you will be responsible for the bill. All referral forms are the responsibility of the patient to obtain.

I understand that payment of charges incurred is due at the time of service (deductibles, copays, and non-covered services) unless other definite financial arrangements have been made prior to treatment.

I hereby authorize and request my insurance company to pay directly to Kensington Ophthalmology the amount(s) due on my claim for services rendered to my dependents or me. I further agree that should the amount be insufficient to cover the entire medical or surgical expense (deductibles, copays or non-insured events), I will be responsible to the doctor for payment of the entire bill and if the bill remains unpaid for ninety days I will be responsible for all billing service fees incurred (thirty percent of the unpaid balance sent to a collections agency).

I understand that due to rising costs, that there will be a $5.00 monthly charge for all balances 30 days past due and there is a $25.00 fee for all checks returned for insufficient funds.

I have read and fully understand the above consent for treatment, financial responsibility, release of medical information and insurance authorization.

____
Name (please print)

____
Signature

____
Date