KENSINGTON
OPHTHALMOLOGY

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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 records to my physicians and insurance company.

It is my responsibility as a patient to know my individual coverage. If my insurance company requires a referral form and I do not obtain one, I 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 (deductible, copay 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 collection 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 also understand if I do not come for a scheduled appointment or I do not give a 24 hour notice to cancel prior to my appointment I will be charged a fee of $25.00

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