315 Hospital Drive, Barbourville, KY 40906 | Phone: (606) 546-4166 | Fax: (606) 546-4167
Email: bfvision@accesshealthky.com | accesshealthky.com

INSURANCE AUTHORIZATION & ASSIGNMENT OF BENEFITS

INSURANCE AUTHORIZATION & ASSIGNMENT

I hereby authorize Access Health Vision to furnish information to insurance carriers concerning my illness, treatments, and to assign directly to Access Health Vision all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance.

I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

FINANCIAL RESPONSIBILITY & OFFICE POLICIES

Please read each statement carefully and initial beside each to indicate your understanding:

☐	I understand that **I am responsible for any amounts not covered by my insurance**, including copayments, coinsurance, deductibles, and non-covered services.
☐	I understand that it is **my responsibility** to know my own insurance plan and available benefits. Access Health Vision will verify benefits as a courtesy, but verification is not a guarantee of payment.
☐	I understand that **insurance estimates are not a guarantee of payment**. Insurance companies may change their reimbursement and coverage at any time. Any balance remaining after insurance processing is my responsibility.
☐	I agree to provide accurate and up-to-date insurance information. If I do not have my current insurance information, my appointment may be rescheduled or classified as **self-pay**.
☐	I understand that **copays and estimated patient portions are due at the time of service**. Acceptable methods of payment include cash, check, debit card, and credit card.
☐	I understand that **returned checks** are subject to a $25.00 returned check fee.
☐	I understand that if I fail to show for my appointment or cancel/reschedule less than **24 hours** prior, a **$25.00 no-show fee** may be applied to my account.
☐	I understand that accounts with outstanding balances over **90 days** may be subject to collection activity. I will be responsible for any collection fees, court costs, and/or attorney fees incurred during the collection process.

MEDICARE PATIENTS (IF APPLICABLE)

Important Notice for Medicare Beneficiaries:
Medicare does **NOT** pay for routine vision services, including refractions (determining the power of your glasses). Medicare does **NOT** pay for the first $240.00 (the annual deductible) in physician fees each year. Medicare generally only pays 80% of allowable charges for medically necessary services. You are expected to pay your portion of these fees at the time of service.

☐ I am a Medicare beneficiary and I understand the above.

CONSENT FOR TREATMENT

I, the undersigned, authorize the performance of any procedures, examinations, and other medically appropriate services as determined by my eye care provider at Access Health Vision, including but not limited to diagnostic testing, medical examinations, and treatment. I also consent to the use of the patient portal for communication regarding my health care.

PATIENT AGREEMENT

By signing below, I certify that I have read, understand, and agree to the above policies. I certify that the insurance information I have provided is accurate to the best of my knowledge. I authorize the release of medical information necessary to process my insurance claims.

PATIENT NAME (PRINTED)

DATE OF BIRTH

PATIENT / GUARDIAN SIGNATURE

DATE

RELATIONSHIP TO PATIENT (IF NOT THE PATIENT)

WITNESS INITIALS