INSURANCE AUTHORIZATION AND BINDING FINANCIAL AGREEMENT

KELLY VISION CENTER
(615) 868-2877

Providing the best possible eye care involves a mutual understanding between patient and provider. Please review the following policies, checkmark in the space provided, and let us know if we can answer any questions.

**Initial in the spaces provided*

_____ I authorize Dr. Marie C. Kelly to release information regarding my care to my insurance company in order to expedite claims or transfer records, should such events be required.

_____ I understand that Dr. Marie C. Kelly participates with vision plans (ex. VSP, EyeMed, & etc.) for routine wellness exams, as well as medical insurances for eye health issues. The appropriate plan will be billed for any given service. Unfortunately, Dr. Marie C. Kelly is unable to participate with every HMO. I understand that if Dr. Kelly does not participate with my plan, I am free to pay out of pocket at the time of service and seek any out-of-network reimbursement directly from my insurer. This office will assist in this effort where possible.

_____ While Dr. Marie C. Kelly makes every effort to verify my insurance coverage and benefits before services are provided, I understand that such information is NOT an official or legally-binding decision of my out-of-pocket expenses. Verification of coverage is done as a courtesy only and is not a guarantee of insurance coverage. Ultimately, my final costs are dependent on the final decision of my insurance carrier. I understand any copay estimate given to me prior to my examination may turn out to be different from the final decision of my insurance carrier. I agree that I am fully responsible to Dr. Kelly for payment of all charges, including any amount in excess of previous copay estimates.

_____ I understand that if my insurance company fails to pay its anticipated balance in full, it is my responsibility to pay the doctor's bill. I will pay collection fees, attorney's fees, court cost, etc. for the purpose of collection on delinquent accounts.

_____ In the event that I receive payment from my insurance company for services provided in this office, I agree to endorse any received payment to the doctor's office.

_____ I give permission for Dr. Kelly to release records to my doctor(s) upon their request.

_____ I request that payment of authorized insurance benefits or any other third-party payer be made to me or on my behalf to Dr. Marie C. Kelly and/or its independent contractor for any services furnished by the provider. I authorize any holder of medical information about me to release to the agents or any third-party payers any information needed to determine these benefits or the benefits payable for related services.

_____ (Account Balances) Kelly Vision Center will require that patients with self pay balances do pay their account balances to $0 prior to receiving further services by our practice. Patients who have questions about their bill(s) or would like to discuss a payment plan option may call and ask to speak to a business office representative with whom they can review their account and concerns. Patients with balances over $100 must make payment arrangements prior to future appointments being made.

_____ I understand there is a 30% restocking fee for all returned materials. There are no refunds after 30 days.

_____ I understand that I must pay 50% of the total payment before my glasses can be ordered. I also understand that my glasses must be completely paid for before I can pick them up.

_____ I understand there is a $45 fee for all returned checks.

This consent was signed by: ____

(PRINT NAME PLEASE)

Signature: ____________________________________ Date: ___________________