Kensington Ophthalmology, P.C. • Holly S. Holm, M.D. • Michelle M. Verplanck, D.O.
10201 E. Grand River Ave. • Brighton, Michigan 48116 • (810) 229-3363

Consent for Treatment

CONSENT FOR EXAMINATION: I understand that medical treatment may be necessary for the patient by Dr. Holm or her associates or assistants. I understand the examination procedures will be explained to me and I shall consent to the partial or complete examination. I understand that the examination results will be provided to me with recommendations. The responsibility for any follow-up examinations to check abnormalities found and treated, lies with me and not with my physician. I hereby release my examiner from all responsibility in connection with this examination.

CONSENT FOR TREATMENT: I understand that medical treatment is necessary for the patient by Dr. Holm or her associates or assistants. I hereby consent to and authorize the administration of all diagnostic and therapeutic treatments that may be considered advisable or necessary in the judgment of the physician. No guarantee or assurance has been given by anyone as to the results that may be obtained by such treatments.

Financial Agreement

1. As a service to you Kensington Ophthalmology participates with Medicare, Blue Cross and many insurance plans. We will submit claims to your insurance company for the medical service that has been provided to you. Insurance claims, which are denied, become the patient's responsibility. Patients with Blue Cross Master Medical coverage will be requested to make payments for office exams at the time of service. It is important that you know what your insurance plan covers. Co-payments, deductibles and non-covered services must be paid in full at the time of service. A schedule of fees for our services is available at the reception desk. We accept cash, checks, and credit cards.
2. **MEDICARE AND MANY HEALTH INSURANCE PLANS DO NOT COVER THE PORTION OF YOUR COMPLETE OPHTHALMIC EXAMINATION CALLED THE REFRACTION - WHICH DETERMINES YOUR NEED FOR AN EYEGLASS PRESCRIPTION. THE CHARGE FOR THIS SERVICE IS$45.00. PLEASE LET US KNOW IN ADVANCE IF YOU DO NOT WISH TO HAVE A REFRACTION**.
3. **If your insurance is a managed care plan, please review your coverage. If your visit requires a referral from your primary care physician (PCP) a copy of the referral form must be received by this office prior to your visit. Failure to obtain necessary authorizations often leads to delays or the need to re-schedule your appointment or to out of pocket expense.** We are happy to assist you in any way with your managed care plan however our experience with these plans has demonstrated that planning and adequate lead time are essential. Your knowledge of your plans regulations and benefits as well as adequate planning will help avoid delays and denied claims.
4. **Many patients have Medical and Optical Insurance.** Your Optical Insurance covers Vision Examinations, often during the examination we find medical problems which must be billed to your Medical Insurance. In this circumstance, we must ask you to schedule an additional appointment for your Vision Examination. Both policies cannot be billed for the same day of service. Please let the receptionist know when you register if you are here for a Vision Examination or a Medical Examination.
5. Your Ophthalmologist is here to handle your medical care and well being. The physicians are not experts on insurance and cannot be aware of all financial arrangements. Please discuss insurance problems and financial arrangements with the business office staff.
6. If you are experiencing financial difficulties please discuss this with the business office staff. We will gladly work with you to make payment arrangements.

☐ **MEDICARE AUTHORIZATION (check if applicable)**
I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. Holm for any services furnished me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on the approved claim forms or electronically submitted claims, my signature authorizes releasing the information to the insurer or agency shown. In Medicare assigned cases the physician agrees to accept the charge determination of the Medicare carrier as the full charge, and I (the patient) am responsible only for the deductible, coinsurance, or noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

☐ **INSURANCE AUTHORIZATION (check if applicable)**
I request that payment of authorized benefits be made either to me or on my behalf to Dr. Holm for any services furnished to me. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim.

I understand and accept the above statements. Witness

_______________________________ _______________________

Signature of Beneficiary (Parent or Guardian) Date

We sincerely appreciate your cooperation and are happy to assist you in any way we can.