Retina Associates of Kentucky
Consent to Treat, Privacy and Healthcare Operations

Please initial each section and sign as indicated at the bottom. If signed by the patient's Power of Attorney, current Power of Attorney documentation must be on file.

_____ CONSENT OF TREATMENT:
I authorize Retina Associates of Kentucky to evaluate and treat me or my family member for the presented condition. I may decline the recommended treatment at any time but I understand if I choose to do so, it is at my own risk.

_____ FINANCIAL RESPONSIBILITY AGREEMENT:
I agree to assign insurance benefits to Retina Associates of Kentucky and authorize all insurance payments to be made directly to Retina Associates of Kentucky. I understand that I am financially responsible for all charges whether or not covered by insurance. I acknowledge full financial responsibility for services rendered by Retina Associates of Kentucky and authorize transfer of all unpaid amounts to me, which includes but is not limited to, co-pays, deductibles, co-insurance, excluded conditions and/or termination of coverage. I understand that payment is expected at the time of service. There will be a fee assessed for returned checks.

_____ PATIENT PRIVACY PRACTICES:
We are committed to ensuring your Protected Health Information (PHI) remains confidential. Your paper and electronic medical records are safeguarded and released only with your consent, and to your insurance carrier, other medical professionals directly involved with your care, or as required by law. Our Notice of Privacy Practices policy, which explains how your medical information may be used and disclosed, is available for your review or you are welcome to have a copy. If you would like to release your PHI to another doctor or facility you will be required to fill out a separate form to request your records. Retina Associates of Kentucky has a training program and sometimes physicians, students or other business professionals may observe your exam or procedure for educational reasons. All images taken or acquired during visits may be shared with other healthcare professionals. No PHI will be associated with the images.

_____ TELEPHONE CONSUMER PROTECTION ACT:
I consent to receive phone calls, emails and/or text messages at any of the phone numbers or email addresses listed on my account for such events as appointment reminders, reschedules, inclement weather closings and to resolve billing issues. I understand I may incur charges from my cell provider and that such calls may be generated by an automated dialing system.

_____ DISABILITY PAPERWORK/FORM COMPLETION/MISSED APPOINTMENT POLICY:
Please give all forms needed completed to Front Office staff. Please do not give these forms to the physician or clinical staff. There is a fee associated with form completion and is determined by the number of pages required to complete, physician review needed, and/or physician time required to complete the request. You will need to expect 7-10 business days for these forms to be completed. Fill out the portion of the form that is for the patient and leave the physician's area blank.

We must be notified at least 24 hours in advance of an appointment cancellation/need to reschedule. A fee may be charged for a no show or late cancellation of appointments.

A copy of the Patient Financial Policy, Patient Cancellation and No Show Policy, and Notice of Privacy Practices are available at the front desk or at www.retinaky.com.

I certify that I have read the financial and privacy policy statements for Retina Associates of Kentucky and agree to the terms within. I also understand such terms may be amended when needed by the practice.

______________________________	______________________________
Printed Name of Patient	RAK Patient Medical Record Number
______________________________	______________________________
Signature of Patient or Guardian	Date