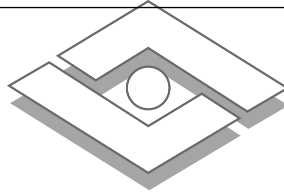
KEITH A. KOBET, M.D., P.C.

Diseases and Surgery of the Eye

KEITH A. KOBET, M.D.

AYAD A. FARJO, M.D.



AUTHORIZATION FOR USE OF DISCLOSURE OF PROTECTED HEALTH INFORMATION:

I authorize my physician and/or administrative and clinical staff of Keith A. Kobet, M.D., P.C. to disclose general medical information and other protected health information to the following persons and/or entities listed below. If no one is listed below, protected health care information will not be disclosed except in those situations described in the Notice of Privacy Practices of Keith A. Kobet, M.D., P.C.

Name and relationship of person(s) who you wish to allow access: (e.g., your spouse, son, daughter, sibling, caretaker, friend)

Name of Person or Entity:	Relationship:

I have been provided a copy of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to read and understand and consent to Keith A. Kobet, M.D., P.C. use and disclosure of protected health information about myself for treatment, payment and health care operations.

____ **Signature of the Patient or Patient Representative**

I authorize the release of any medical information necessary to process all claims and I authorize the release of payment for medical benefits to Keith A. Kobet, M.D. and Ayad A. Farjo, M.D. All copays and non-covered services are due at the time of service.

What is a refraction and why do I have to pay for it? The refraction is a test to determine your correct glasses prescription. Medicare and most other medical insurance companies DO NOT cover this service. For this reason, the refraction portion of the examination is coded and charged separately. If you have additional vision insurance you may be able to submit these charges to them for reimbursement. The patient charge for the refraction is : $35. 00

In conclusion, we must emphasize that as medical and surgical providers, our relationship is with you our patient, not with your insurance company. While we are happy to file a claim for payment with insurance companies on your behalf, please know that the ultimate responsibility for payment toward services rendered remains your.

By signing below, I acknowledge that I have read and understand the Financial Policy of Keith A. Kobet, M.D., P.C. and agree to the payment terms and my obligations under the Financial Policy.

____ **Signature of the Patient or Patient Representative**

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Diplomates, American Board of Ophthalmology