Name:

DOB:

AUTHORIZATION FOR CONSENT, RELEASE OF INFORMATION & FINANCIAL AGREEMENT

1. By signing below, I hereby authorize my health information, as more specifically described below, to be used or disclosed: For treatment, payment, or healthcare operations (this health information is referred to herein as "Protected Health Information"). The specific person or class of persons who are authorized to use or disclose my Protected Health Information are as follows: Any employees or agents of the practice. I understand that I have the right to revoke this Authorization by giving notice in writing to the Privacy Officer. If the revocation is in writing, except if the practice has taken action in reliance upon this Authorization, or if this Authorization was given as a condition of obtaining insurance coverage, other law provides that the insurance company has the right to contest a claim under the insurance policy. I understand that my Protected Health Information that is used or disclosed under this Authorization may be subject to re-disclosure by the recipient, and the privacy of my Protected Health Information will no longer be protected by the law.

2. AUTHORITY FOR TREATMENT: I hereby authorize the doctor and the associates or assistants of his/her choice to treat my/the patient's condition, this also includes the treatment of a minor (under the age of 18). I understand that possible risks are present in any treatment or procedure that may be performed, and that my/the patient's physician will explain these prior to initiating any treatment or performing any procedure. I acknowledge that no representations, warranties or guarantees as to the results or cures have been made to me or relied upon me. I agree that the practice can request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payers for treatment purposes.

3. KASPER/OARRS/INSPECT: In accordance with State law, your physician is required to take additional steps before prescribing some controlled substances. Your physician may have to obtain a KASPER/OARRS/INSPECT report on you, as well as meet other administrative treatment requirements. KASPER/OARRS/INSPECT is an electronic system that monitors schedules II, III, and IV controlled substances prescribed by your physicians and filled in a pharmacy. KASPER/OARRS/INSPECT is administered by the Cabinet for Health and Family Services. If prescribed a controlled substance, I understand all of the rules and guidelines should be followed. I acknowledge that my individual KASPER/OARRS/INSPECT report will be maintained in my medical record.

4. FINANCIAL AGREEMENT: In consideration of the services to be rendered to me, I hereby individually obligate myself to pay the account of the practice in accordance with the regular rate and terms of the practice. Should the account be referred to an attorney or licensed collection agency for collection, I shall pay, attorney's fees, court cost, collection fees and collection expense. I understand, as a courtesy, the practice will file my primary, secondary and tertiary insurance. I agree that any account balance which is my responsibility will be paid within 12 months from the date of service. Any claim not paid by insurance will be the patient's responsibility. All surgeries which are elective may require a 50% deposit before the surgery is performed and/or insurance deductibles will be collected. I understand if I have a balance on my account which is considered Bad Debt, I must pay the balance in full before I can be seen. If I have no insurance, I will be required to pay a deposit before I can be seen. Patient credit balances may be refunded once all claims have been processed by the insurance company. Refunds will be issued in the form of a check regardless of how the payment was made. There is an administrative fee for any returned refund checks or refund checks that have to be re-issued.

5. NOTICE OF PRIVACY PRACTICES: I acknowledge that I was offered the practice's Notice of Privacy Practices ("Notice"). I understand that copies are available upon request and the Notice is posted in the office. In addition, the Notice is available on our website, www.The practice.com.

6. MEDICARE COMPLIANCE: The practice is committed to Medicare Compliance. If you have a complaint or question regarding the Medicare Policies of our practice, please contact our Compliance Officer at 859-301-2663.

7. I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act (Medicare or Medicaid) is correct. I understand that I am financially responsible for payment for medical services rendered by The practice that are not paid by my insurance carrier, Medicare, Medicaid, or its intermediaries within the terms of the applicable insurance policy. I assign to The practice all rights to payment or reimbursement for this medical care, authorize that my payments be made directly to The practice and agree that The practice has the right to participate on its own behalf in any claim for payment for these services. I authorize the practice to release completed medical information to my insurance carrier, Medicare, Medicaid or its intermediaries as required to obtain payment for these claims. I authorize this individual to make any request; to present or to elicit evidence; to obtain appeals information; and to receive any notice in connection with my appeal, wholly in my stead. I understand that personal medical information related to my appeal may be disclosed.

8. I authorize The practice to release medical, billing and other information about me to (a) any person, company or entity (including but not limited to HMO's, insurance companies, workers' compensation carriers, liability or auto carriers, my employer, CMS and their intermediaries and review organizations, any other payer or its review organization or third party administrator) who is or may be liable for paying a claim for benefits arising out of services provided to me; (b) any physician or independent practitioner providing services for me; (c) any providers who may be providing follow-up care to me after discharge such as home health agencies, nursing homes and physicians; and (d) any licensing or accrediting organization necessary to obtain or maintain licensure or accreditation.

9. For any Worker's Compensation patient, the practice requires all other private medical insurance coverage information at the time of registration. If any Worker's Compensation claim is unpaid or services are denied by Worker's Compensation, The practice will bill the private medical insurance company and the patient will be responsible for any remaining balance.

10. Please be advised that the parent/guardian accompanying the minor at the initial office visit is responsible for copayments and for services provided at that visit even if another parent/guardian has been determined by a court to be financially responsible.

11. The practice will utilize a texting platform for most appointment reminders. Your signature below means you acknowledge that you may receive communications from the practice through texting.

By signing this Authorization, I acknowledge that I have read and understand this Consent and Authorization. Further, I authorize the use and disclosure of my Protected Health Information in accordance with the terms of this Authorization.

Signature (Patient) Date

Signature (Legal Rep.) Date

Printed

Relationship to Patient

Signature (Witness) Date