FINANCIAL POLICY

The Doctors and Staff at the Kutryb Eye Institute would like to welcome you to our practice. We will strive to provide you with excellent medical care and our goal is to make your visits as pleasant as possible.

By signing below, you confirm that you have read this policy and understand that:

- It is your responsibility to inform our office of any address or telephone number changes.
- Our office sends monthly statements on all accounts with an outstanding balance to the address we have on the account.
- Your account is to be kept current accordingly, all self-pay, or insurance co-payments, co-insurances and deductibles will be collected at **the time of service**.
- Payments can be made by cash, check, Visa, or MasterCard.
- A returned check will result in a $25.00 service charge and all future payments will be required in the form of cash or credit card.
- We reserve the right to charge for appointments cancelled or broken without 24 hours advanced notice.

If you have health insurance coverage:

We will submit your claims; however, we must emphasize that as medical providers, **our relationship is with you** not your insurance company.

By signing below, you confirm that you understand:

- It is your responsibility to inform us of any changes to your insurance policy so that your coverage can be re-verified prior to your appointment.
- Not all services are covered benefits with all insurance plans.
- It is your responsibility to be aware of what service(s) is being provided to you and if it is a covered benefit under your insurance policy.
- You are responsible for any not covered charges not payable by your insurance policy.
- We do not file third insurance companies, only primary and secondary.
- Although filing your insurance claims is a courtesy extended to you, all charges are always your responsibility from the date services are rendered.

Patient Name:	Patient Signature:	Date:
Responsible Party Name:	Responsible Party Signature:	Date:

Michael J. Kutryb, M.D.
Board-Certified Ophthalmologist

321-267-2020

730 S. Washington Ave
Titusville, FL 32780

ASSIGNMENT OF MEDICARE BENEFITS

Medicare Number:

I request that payment of authorized Medicare benefits be made on my behalf of **KUTRYB EYE INSTITUTE** for any service furnished to me via a Physician of a group. 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 payable for related services. In Medicare assigned cases, the provider agrees to accept the charge determination of the Medicare carrier and I am responsible for the Medicare deductible, co-insurance, or the 20% Medicare does not pay, and for any non-covered services.

My signature below further verifies that I have not joined an HMO or other entity in which my Medicare benefits have been relinquished.

Patient Name:	Patient Signature:	Date:

MEDIGAP OR OTHER SECONDARY INSURANCE

Medigap Name:	Medigap Number:

I request that the payment of authorized Medigap benefits be made either by me or on my behalf to Kutryb Eye Institute, or any physician of that group, for services provided to me by a physician of that group. I authorize any holder of medical information about me to release it to my Medigap insurer, or any information needed to determine these benefits for related services.

The assignments shall remain in effect until revoked by me in writing. A photocopy of this assignment is considered as valid as the original.

Patient Name:	Patient Signature:	Date:

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KUTRYB EYE INSTITUTE

Patient Forms

Routine Eye Exams vs Medical Eye Exams

****Please Read Before Your Eye Exam****

Regular eye examinations are important to maintain your vision for your lifetime. We hope this information will help you to understand how your visit is billed to your insurance(s) for today's visit as well as your future visits with Kutryb Eye Institute. Ultimately, it is your responsibility to know what your insurance covers.

Benefits vary based upon the reason for your visit. Your symptoms and examination findings will determine how your visit is coded and billed to your insurance(s).

*A **Routine (Annual) Eye Exam**: a regular eye exam not related to any medical issues of the eye or otherwise, in which case we can bill your vision plan, if eligible.

*A **Medical Eye Exam**: a medical-related complaint exam, follow up to existing medical condition, and/or medical findings *during* your exam, in which case we must bill your health insurance(s). Examples include: diabetes mellitus, dry eye, allergies, cataracts, glaucoma, eye muscle imbalance and/or macular degeneration.

In summary, your eye exam will be submitted to your Medical and/or Vision insurance carrier based on what the doctor finds upon examination: meaning, **a routine exam can turn into a medical exam according to what the doctor has diagnosed during your visit.** You understand that you are responsible for any co-pays, deductibles and/or co-insurances as determined by you insurance carrier. Your signature below indicates that you understand this process as outlined and that you recognize the difference between a "Routine" and a "Medical" examination. **Please reach out to a member of our staff with any questions or concerns *before* signing this form.**

_____ _____

Signature Date

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REFRACTION SERVICE AND FEE

Refraction is the process of determining if there is a need for corrective eyeglasses. It is an essential part of the comprehensive eye exam and is necessary to write a prescription for eyeglasses.

Most insurance plans, including Medicare do NOT cover this service. Medicare requires a separate charge for that portion of the exam, since it is a non-covered service.

Our office fee for the refraction is $50.00, which we reduce to $30.00 for patients paying at the time of service.

Thank you for trusting Kutryb Eye Institute with your vision care.

Patient Signature:	Date:

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Name: _____ **Sex:** _____ **Date Of Birth:** _____ **Date:** _____

Are you presently under the care of a physician? ☐ **No** ☐ **Yes**
Are you allergic to any medications? ☐ **No** ☐ **Yes**
If so, please list: _____

PLEASE CHECK ALL OF THE SYMPTOMS YOU EXPERIENCE:

__Redness
__Eye Pain/Soreness
__Chronice infection of eye or lids
__Itching/Burning
__Light Sensitivity
__Mucous Discharge
__Sandy or Gritty Feeling
__Fluctuation Visual Actuity
__Dry Eye Feeling
__Sties/Chalazion
__"Tired" Eyes
__Other

Do you use lubricating eye drops? ___Yes ___No What name brand? _____
Do you wear contact lenses? ___Yes ___No How long have you had them? _____
Are they comfortable? ___Yes ___No Have you tried to wear them before & quit? **Y N**
Do you wear glasses? ___Yes ___No How long have you had them? _____
Have you ever had an eye injury? ___Yes ___No Describe: _____
Have you ever had eye surgery? ___Yes ___No Describe: _____

OVERALL MEDICAL HISTORY

Please indicate if you or a blood relative have or have had any of the following conditions:

Diabetes	___No	___Self	___Family	Relationship: _____
Heart Disease	___No	___Self	___Family	Relationship: _____
High Blood Pressure	___No	___Self	___Family	Relationship: _____
Cancer	___No	___Self	___Family	Relationship: _____
Asthma/Respiratory	___No	___Self	___Family	Relationship: _____
Arthritis	___No	___Self	___Family	Relationship: _____
Epilepsy	___No	___Self	___Family	Relationship: _____
Stroke	___No	___Self	___Family	Relationship: _____
Headaches/Migraines	___No	___Self	___Family	Relationship: _____
Glaucoma	___No	___Self	___Family	Relationship: _____
Allergies	___No	___Self	___Family	Relationship: _____
Gastrointestinal/Liver	___No	___Self	___Family	Relationship: _____
Blood Related Problem	___No	___Self	___Family	Relationship: _____
Kidney Stone	___No	___Self	___Family	Relationship: _____
Kidney Failure	___No	___Self	___Family	Relationship: _____

Social Histoy

Do you smoke? ___Yes ___No Packs per day: _____
Do you drink alcohol? ___Yes ___No Drinks per day: _____
Do you use street drugs (cocaine, marijuana,etc.) ___Yes ___No

Patient Signature: _____ Date: _____

MEDICATION LIST

Patient Name:	Allergies:

DATE	MEDICATION NAME	DOSAGE / FREQENCY
Start:		
Stop:		
Start:		
Stop:		
Start:		
Stop:		
Start:		
Stop:		
Start:		
Stop:		
Start:		
Stop:		
Start:		
Stop:		

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KUTRYB EYE INSTITUTE

Patient Forms

Last Name:		First Name:	Middle Initial:
Patient Address:			
City:	State:	Zip:	Phone:
Date of Birth:	Sex: M ◯ F ◯	Married Status: M ◯ S ◯	Referred by:
Patient Social Security Number:		Ethnic Origin: Native American ☐ Asian ☐ Black ☐	
Patient Employer:		Caucasian ☐ Latin ☐ Other ☐ No Response ☐	
Employer Address:			
City:		State:	Zip:
Employer Phone:		Extension:	
Responsible Party Last Name:		First Name & Middle Initial:	Relationship:
Address:			
City:	State:	Zip:	Phone:
Responsible Party Date of Birth:		Responsible Party Social Security Number:	
Spouse Name:		Spouse Work Phone:	

IN CASE OF EMERGENCY

Nearest Living Relative or Friend Not Living with You:	Relationship to Patient:
Relative or Friend Home Phone:	Relative or Friend Work Phone:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Kutryb Eye Institute or insurance company to release any information required to process my claims.

Patient/Guardian Signature: _____ Date: _____

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PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance to you prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health operations.
- The Practice has a Notice of Privacy and that I have received this Notice.
- The Practice reserves the right to change the Notice of Privacy Policies.
- I have the right to restrict the uses of their information but the Practice does not have to agree with those restrictions.
- I may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition treatment upon the execution of this Consent.

Patient Name:	**Patient Signature:**	**Date:**
Responsible Party Name:	**Responsible Party Signature:**	**Relationship to Patient:**
Signature of Staff Witness:		**Date:**

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