



501 Baptist Dr. Suite 220  
Madison, MS 39110  
601-985-9120  
FAX 601-985-9122  
www.eyegroupms.com

William Ashford, M.D.  
Kevin Kosek, M.D.  
Elizabeth Wyatt Mitchell, M.D.

**PLEASE READ AND SIGN THE STATEMENTS BELOW**

I request that assignment of my healthcare insurance benefits be made to Drs. Elizabeth Wyatt Mitchell and/or William Ashford, and/or Kevin Kosek for any services furnished to me. I authorize the release of any medical information necessary to process these claims.

In order to decide if glasses are necessary and to get the correct prescription you must be refracted. Medical insurance plans will not cover this. You will be responsible for this fee on the date of service. I understand and agree with the above information.

**Patient or Responsible Party Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

I understand that I, the patient or patient representative, are responsible for payments of charges for services rendered. A service charge of 1-1/2% plus collection fees may be added to any outstanding balance due from patient. I give my consent to receive communications from servicers and collectors of my accounts, through 1) cell, landline, or text numbers that I provide, 2) email address that I provide, 3) auto dialer systems, 4) voicemail messages, and other forms of communications.

**Patient or Responsible Party Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

I understand that it is my responsibility to check with my insurance company to verify that the Eye Group physicians are in my insurance network.

**Patient or Responsible Party Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

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**PATIENT ACKNOWLEDGEMENT OF  
RECEIPT OF NOTICE OF PRIVACY PRACTICES**

Our **Notice of Privacy Practices** provides information about how we may use and disclose protected health information about you. You have the right to review our Notice of Privacy Practices before signing this acknowledgement.

A copy of our **Patient Rights and Responsibilities** has also been provided to you, and explains your rights as a patient in the event that an in office or surgical procedure is to be performed.

As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy by requesting a copy in writing from:

Privacy Officer  
Eye Group  
501 Baptist Drive, Suite 220  
Madison, MS 39110

By signing this form, you acknowledge that you have been provided a copy of and have reviewed our **Notice of Privacy Practices** and our **Patient Rights and Responsibilities**, and have no further questions regarding these forms.

**Patient or Responsible Party Signature** \_\_\_\_\_ **Date** \_\_\_\_\_



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**IMPORTANT MEDICAL/VISION INSURANCE INFORMATION**

Thank you for choosing to trust **Eye Group** with your eye care. Our goal is to provide the best care and patient experience available. The information below is provided in an effort to help clarify the role of vision insurance and medical insurance in your care at our office.

\_\_\_\_\_  
(Initial)

***Many of our patients have both Vision and Medical Insurance. It is the policy of our office to file with only one type of insurance at each visit, either Vision or Medical. The determination of which insurance is filed is based on the diagnosis made by your physician. If your visit results in a medical diagnosis, only your medical insurance will be filed. In this case, if you would like to file a claim against your vision plan, please request a copy of your superbill upon checkout.***

\_\_\_\_\_  
(Initial)

***We will file Vision Plans only when your physician determines your visit to be a normal/routine exam (example glasses or contacts) and no medical diagnosis is present. If a medical diagnosis is found (example dry eye, cataract, etc.) your Medical Insurance will be filed. Upon checkout we will know if you have a medical diagnosis and your Medical Insurance will be filed or if your exam was routine only and your Vision Insurance will be filed.***

\_\_\_\_\_  
(Initial)

***Because there is great variability in the benefits among individual Vision Plans and Medical Insurance, it is not possible for us to determine on the date of service the exact amount you will owe to the doctor for the exam, refraction, the contact lens fitting process, and/or contact lens supply. Please understand there is a possibility you will be billed further for any amount your insurance plan deems non-covered. The amount you may have paid in the office is an estimate only.***

\_\_\_\_\_  
(Initial)

***If you do not have a medical diagnosis, and the exam, refraction, the contact lens fitting process, and/or contact lens supply can be filed on your Vision Plan, the contact lens fitting of \$50.00 is to be paid up front by you, the patient. You will be refunded for the contact fitting fee 7 – 10 days after our office receives payment from your vision plan. \*\*\*Please see the Contact Lens Policy\*\*\****

We hope this information is helpful in explaining the role of Vision and Medical Insurance. We also have a dedicated billing staff that is available to assist you at any time at your request. We thank you again for choosing us to be your eye care provider.

Patient Signature \_\_\_\_\_

Date \_\_\_\_\_



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**Authorized Release of Personal Medical Information**

Please list family member/others who may need to speak with any of our staff regarding, but not limited to, your medical information such as:

- Coordination of Care
- Billing / Insurance
- Scheduling

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone Number \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone Number \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone Number \_\_\_\_\_

**Please list any Specific Instructions or Limitations:**

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**This authorization will remain in effect unless request is received by our office in writing.**

By signing this form, I authorize the release of my personal medical information to above persons.

\_\_\_\_\_  
Patient / Authorized Signature

\_\_\_\_\_  
Date



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Please read each statement and initial documenting that you reviewed and understand the policies.

**Breach of Security Statement**

In the event of a security breach or other system wide correspondence that requires my notification, I authorize you to contact me by the email address I provided to you.

\_\_\_\_\_  
Initial

I understand that:

- If I do not have access to email, that I will be informed by phone or mail;
- That I am responsible for giving you any updates of my email address; and that **Eye Group** will not be held responsible if they are unable to contact me if I have not done so.

**Fee for Release of Records**

I understand that there may be a charge for providing me or my representative(s) with copies of my medical records in accordance with the guidelines provided by the MS State Board of Medical Licensure.

\_\_\_\_\_  
Initial

**Fee for Completion of Forms**

I understand that there may be a charge for the completion of forms such as, but not limited to, FMLA, appeals, physicals, workman's compensation, etc.

\_\_\_\_\_  
Initial

**Fee for Same Day Work-In**

If I have a medical problem and seen as a same day work in patient, I may be charged CPT Code 99058. This charge may not be paid for by my insurance company.

\_\_\_\_\_  
Initial

**Patient Communication**

I understand the Eye Group and/or The Eye Surgery and Laser Center, LLC may use phone texts to contact me for appointments, upcoming events, or educational purposes.

\_\_\_\_\_  
Initial

Signature \_\_\_\_\_

Date \_\_\_\_\_

Printed Name \_\_\_\_\_