COMMONWEALTH
EYE SURGERY

(859) 224-2655 | 2353 Alexandria Drive, Suite 260 | Lexington, KY 40504

Lance S. Ferguson, M.D. | Gary N. Wörtz, M.D. | Howell M. Findley, O.D. | R. Marty Smith, O.D. | Lance Long, O.D.

ONE-TIME MEDICARE AUTHORIZATION STATEMENT

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to Lance S. Ferguson, M.D., P.S.C. and Commonwealth Eye Surgery Center, which accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provide penalties for withholding this information.) Regulations pertaining to Medicare assignment of benefits also apply.

Patient's (or authorized person's) signature: _____ Date: _____

MEDIGAP AUTHORIZATION STATEMENT

I authorize any holder of medical or other information about me to release any information needed for this or a related Medigap claim and future claims. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to Lance S. Ferguson, M.D., P.S.C. and Commonwealth Eye Surgery Center, which accepts assignment.

Patient's (or authorized person's) signature: _____ Date: _____

OTHER INSURANCE AND MANAGED CARE AUTHORIZATION STATEMENT

I authorize any holder of medical or other information about me to release any information needed for this or a related claim and for future claims. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to Lance S. Ferguson, M.D., P.S.C. and Commonwealth Eye Surgery Center, which accepts assignment. (I understand that I am financially responsible for all services performed at Commonwealth Eye Surgery for which I did not provide a current referral form.)

Patient's (or authorized person's) signature: _____ Date: _____

LASER VISION CORRECTION CONSULTATION AGREEMENT

I understand that this office visit is for a free LASIK consultation and that no continued or subscriptive care (i.e., glasses, contacts or medications) will be given as a result of this visit. Any incidental medical findings that may require further medical treatment will need to be treated as a separate medical evaluation subject of the usual and customary charges associated with a medical evaluation. I understand that requirements of LVC differ among military branches and realize I am responsible for researching these requirements if I serve or plan to serve in the military.

Patient's (or authorized person's) signature: _____ Date: _____

CONCERNING BILLING & INSURANCE

1) Patients who are not covered by health care insurance should remember that we expect payment in full (or appropriate payment arrangements) for all services at the time of each visit. You may pay by cash, personal check, VISA, MasterCard and Discover. You may also apply for monthly financing at CareCredit.com.

2) If your insurance requires a referral, please obtain your referral from your primary care physician prior to your appointment date and bring it with you. (If you are unsure of your policy or have questions, please contact your insurance company)

3) If you require or would like a member of your party to be present during your exam, please make that decision prior to being called back by our technicians. Out of respect for the privacy of all of our patients, we ask that all other members of your party remain in the front lobby until your exam is finished. In case of an emergency, we will locate a member of your party immediately.

4) We are also participating providers for most insurance plans. Please check with your insurance to confirm.