JOHN-KENYON

4040 Dutchmans Lane, Louisville, KY 40207
519 State Street, New Albany, IN 47150
1305 Wall Street, Jeffersonville, IN 47130
1.800.DIAL EYE | (812) 948.0616

Thank you for choosing JOHN-KENYON

CONFIDENTIAL

FINANCIAL POLICY

CONTRACT TO PAY FOR MEDICAL SERVICES RENDERED BY
JOHN-KENYON AMERICAN EYE INSTITUTE

FILING INSURANCE CLAIMS

Insurance will be filed on all surgery patients; however, the filing of private insurance for office visits is the sole responsibility of the patient, unless we are a provider of that insurance. We will file your secondary one time only. After 60 days we will require payment in full. You may then pursue with the insurance company.

If there is any overpayment it will be reimbursed to you. Should you prefer to file your insurance yourself, you may do so with the itemized bill provided. Please understand that coverage varies significantly among the many insurance carriers, therefore, it is your responsibility to thoroughly understand the coverage, exceptions and limitations of your particular policy. Awareness of the unique provisions of your policy will aid in meeting your deductible and limiting complicated paperwork for you.

Please notify our Billing Department of any changes in your insurance coverage.

I AGREE AND UNDERSTAND IT IS MY RESPONSIBILITY TO PROVIDE ACCURATE INSURANCE INFORMATION. IF ACCURATE INFORMATION IS NOT PROVIDED ON DATE OF SERVICE OR IF THE PATIENT HAS NO INSURANCE COVERAGE, THE PATIENT IS SOLELY RESPONSIBLE FOR THE FULL BILL.

SELF-PAY PATIENTS

Payment for medical care is expected at the time of service.
We accept cash, check, Care Credit and all major credit cards.

By signing this form you agree to be held liable for all JOHN-KENYON American EYE Institute expenses, costs and reasonable attorney fees along with collection agency fees for any delinquent balance.

Signature _____ Date _____