VIRGINIA EYE INSTITUTE

Name: _____

Chart number: _____

- **CONSENT FOR TREATMENT**

  I authorize Virginia Eye Institute to provide medical treatment to myself and/or my dependent. In the event that any employee is exposed to my blood and/or body fluids, I consent to laboratory testing of my blood and/or body fluids. I consent to laboratory testing of my blood for Hepatitis B and/or C and AIDS antibody and agree for the results of such test to be released to the person who has been exposed.

- **ASSIGNMENT OF BENEFITS**

  I request that payment of authorized Medicare, Medicaid or applicable private insurance benefits be paid directly to Virginia Eye Institute for services provided by Virginia Eye Institute physicians and employees.

- **RELEASE OF MEDICAL INFORMATION**

  I authorize Virginia Eye Institute to release necessary medical information to my insurance company, its agents, or to any third party payer in order for payable benefits for these services to be determined.

- **FINANCIAL RESPONSIBILITY**

  I understand that I am responsible for paying my co-pay at the time of service, if unable I can be asked to reschedule a non-emergency appointment.

  I understand that Virginia Eye Institute will file my insurance claims as a courtesy; however, I am ultimately responsible for full payment of all charges not covered by insurance(s). Should collection proceedings or other legal action become necessary to collect an overdue account, the patient or the patient's responsible party, understands that the practice has the right to disclose to an outside collection agency all relevant personal and account information necessary to collect payment for services rendered. The patient, or the patient's responsible party, understands and agrees to pay all collection fees in the amount up to thirty three and one-third percent (33 1/3%) of the total unpaid balance due, plus court costs and filing fees incurred by the practice. I understand and agree that should the practice be awarded judgment relating to this agreement or any debt incurred thereof, I will pay a service charge of one and one-half percent (1 ½%) per month, eighteen percent (18%) per annum, beginning on the date of judgment.

  I understand that if I have a high deductible insurance plan and if the deductible is not met, I will be required to pay $150 deposit at time of service. Once my insurance has been billed, any balance will be my responsibility.

  I understand that I am responsible for my entire visit if I have no insurance and will be considered Self-Pay. I am required to pay $150 upon arrival and any additional that may be due at check-out.

- **REFERRALS/AUTHORIZATION**

  I understand if my insurance company requires a referral, I am responsible for obtaining a referral prior to my visit. If I do not have a referral I will be required to sign a waiver and pay $150 before being seen by the physician. Payment in full for services rendered during the office visit will be collected at the check-out desk.

- **MISSED APPOINTMENTS**

  We require at least 24 hours notice if you must cancel an appointment. Failure to do so may result in a $25 "no show" fee.

- **REFRACTION**

  Refraction is part of an eye examination used to determine the focusing error of the eye and the proper prescription for glasses. Refraction is considered by many medical insurances to be a NON-MEDICAL test and is frequently a NON-COVERED service. Patients whose insurer does not cover refractions are expected to pay $40 for the service along with any applicable co-payments or deductibles, on the day of service. Patients may request that the refraction not be done. If you have any questions, please discuss them with your physician's staff in the exam room.

  I have read the above statements and I understand my responsibilities. A copy of the authorization will be considered as valid as the original.

_____ _____

Signature of Patient or Responsible Party Date