Virginia Eye Institute
BRINGING YOUR WORLD INTO FOCUS

Name: _____

Chart number: _____

CONSENT FOR TREATMENT AND FINANCIAL POLICY

Thank you for choosing the **Virginia Eye Institute (VEI)** for your health care needs. This consent form and patient financial policy has been developed to assist in answering your questions regarding patient and insurance responsibility for services rendered. Your understanding of and compliance with our patient financial policy is important. Please read the policy below and ask the staff any questions you may have and sign as indicated. The original will be maintained in your file and a copy may be provided to you upon your request.

- **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.

- **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 financially responsible and agree to pay all of the charges that are not paid or billed to insurance or any other third party payer. I understand that I must pay in full today for all services rendered unless my insurance is accepted. I also understand that if my insurance is accepted, I must pay all applicable insurance copays, coinsurances, and deductibles today. If you are unable to verify my insurance at time of service, I will pay in full for all services.

  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 Virginia Eye Institute 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 and reasonable attorney 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. I understand and agree that should the practice be awarded judgment relating to this agreement or any debt incurred thereof, I will pay interest in the amount 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 my deductible has not been met at the time of service, 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 a $150 deposit upon arrival and any additional amount that may be due at check-out.

1. **INSURANCE POLICY:** Your insurance policy is a contract between you and your insurance carrier. You are responsible for providing our practice with the correct insurance information at the time of service or you may be responsible for the charges in full. Should your insurance company fail to pay the insurance claim for services rendered by the Virginia Eye Institute you may be responsible for the entire charges submitted to the insurance carrier. Therefore, we recommend that you follow-up with the insurance carrier if your claim has not been paid within 30 days from the date the services were rendered.

2. **ASSIGNMENT OF BENEFITS:** I request that payment of authorized Medicare, Medicaid or applicable 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.

3. **CO-PAYMENTS, DEDUCTIBLES, & CO-INSURANCE:** Patients are expected to pay AT THE TIME OF SERVICE all amounts that are not covered by their insurance company. These amounts include co-payments, co-insurance, and/or deductibles. Payments may be made by cash, check, and/or credit card (MasterCard, Visa, Discover, American Express).
    a. I understand that if I have a high deductible insurance plan and if the deductible is not met, I will be required to pay a $150 deposit at the time of service. Once my insurance has been billed, any balance will be my responsibility.
    b. Patients who are unable to pay their co-pays and/or non-covered charges at the time of service may be asked to reschedule their visit.

4. **REFRACTION:** Refraction is the measurement of the focus error of an eye. It determines the set of lenses that will best focus the light entering the eye. The results of a refraction are used to: (a) determine the health and visual potential of an eye; (b) aid in performing tests such as visual fields; and (c) to prescribe glasses and/or contact lenses
    a. Refraction is considered a "non-medical" service by most insurance companies and is therefore most usually a non-covered service. **The REFRACTION FEE is $70.00** and is due at time of service, if performed as part of the patient's examination.

5. **REFERRALS:** Some patients will be required by their insurance company to obtain a "referral" from their Primary Care Physician authorizing their visit to the Virginia Eye Institute specialist. It is the patient's responsibility to obtain this referral and to be sure that the referral is communicated to the Virginia Eye Institute before the patient's visit.
    a. A patient presenting at the Virginia Eye Institute without a required referral will be asked to sign a waiver by which he/she agrees to pay all charges generated by the visit, if a referral is not obtained to cover the visit. The patient will also be expected **to pay a $150.00 deposit** at registration for their office visit and any additional charges at the end of their visit.
    b. If a referral is ultimately received for the visit and if the insurance pays, a refund will be sent to the patient reflecting the insurance payment.
    c. Patients are reminded that many physician offices will not provide a retroactive referral.
    d. Patients presenting without a required referral and who do not agree to sign a waiver and are unable to **pay at least the $150.00 deposit** may be asked to reschedule their VEI appointments.

6. **SELF-PAY PATIENTS:** Self-pay patients (i.e., patients with no health insurance) will be **expected to pay a $150.00 deposit** at registration for their office visit and any additional charges at the end of the visit upon checking out. Payment in full is expected on the date of service. The person paying the additional charges at the end of the visit may be given a prompt pay discount if all services are paid in full on the date of service. There may be situations where the physician has not yet documented, by the time of checkout, the services provided to the patient. If this happens, then the practice will bill the patient for any outstanding or remaining charges.

7. **OPEN BALANCES:** Patients with open balances on previous office visits or surgical procedures will also be asked to pay 50% of any open balances at the time of the new visit. Patients who are unable to pay the 50% on any open balances may be asked to reschedule their visit. Exceptions to the 50% may only be made upon approval through the Business Office, the Lead Patient Care Representative (Supervisor), the Associate Director of Revenue Cycle Management, or the Director of Revenue Cycle Management.

8. **COLLECTION FEES:** Patient accounts which have not been paid by the patient and/or insurance for 90 or more days since the office visit may be referred to a collection agency or attorney for collection. The patient agrees to pay costs, which could include reasonable attorney fees, court filing fees or other reasonable costs of collection efforts, in addition to the account balance.

9. **BILLING OFFICE:** Patients who are experiencing difficulty in making payments on open accounts are asked to contact a VEI Patient Account Representative at (804) 287-4213 in order to establish a fair and appropriate payment plan. Patients may be asked, in these circumstances, to provide financial income information, which VEI can use in determining an appropriate and fair monthly payment.

10. **MISSED CLINIC APPOINTMENTS:** Please help us serve you better by keeping scheduled appointments. In the event you are unable to keep your scheduled appointment, please give a 24 hour notice. Failure to provide this 24 hour notice of cancellation will result in a $50 missed appointment charge.

    MISSED SURGERY APPOINTMENTS: Patients who fail to show for their scheduled surgery (including laser procedures) appointment or did not notify the office within 7 days in advance (if surgery/laser is scheduled on a Monday, must cancel by prior Monday) of their scheduled surgery appointment time, shall be subject to a "No Show" fee of $150.00.

    MISSED OCCULOPLASTIC SURGERY APPOINTMENTS: Patients who fail to show for their scheduled surgery (including laser procedures) appointment or did not notify the office within 14 days in advance of their scheduled surgery appointment time, shall be subject to a "No Show" fee of $150.00

    THESE CHARGES ARE THE RESPONSIBILITY OF THE PATIENT AND WILL NOT BE SUBMITTED TO ANY INSURANCE CARRIER.

11. **RETURNED CHECKS:** There will be a $35 fee assessed to your account for any check returned to our bank as unable to process for any reason.

Consistent with state and federal privacy laws, and as a condition of treatment, audio or video recordings are not permitted inside Virginia Eye Institute facilities. Should anyone be observed recording or taking photographs with a cellphone or other device, the individual will be asked to immediately erase the audio, video or photographs to protect the privacy of other patients and VEI associates.

Photographs or recordings of a doctor may be taken only with the doctor's permission and only if no other patients are captured in the images or recordings.

I have read and understand the practice's Consent for Treatment and Financial Policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time. A copy of the authorization will be considered as valid as the original.

_____ _____

Signature of Patient (or Guarantor, if applicable) Date

_____

Authorization for Release of Information

Name of Patient: _____ Date of Birth: _____

VIRGINIA EYE INSTITUTE is authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions. VEI or its authorized agents, to include debt collection professionals, may contact me by telephone, to include mobile phones I am authorized to use, and may use electronic means of managing these phone calls to me.

Appointment Reminders and test results can be left on my answering machine. Yes No

Medical and Financial information may be given to my spouse. Yes No

Other:_____ Relationship:_____ Yes No

Patient Information:

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to disclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient.

Acknowledgement of Receipt of Notice of Privacy Practices

I have received or have been offered a copy of the Notice of Privacy Practices for the above named practice. I understand that I may ask questions to the Virginia Eye Institute if I do not understand any information contained in the Notice of Privacy Practices.

_____ Date _____

Signature of Patient or Personal Representative (relationship to patient)

Description of Personal Representative's Authority (attach necessary documentation)

For Office Use Only

We were unable to obtain a written acknowledgement of the above because:

- An emergency existed & a signature was not possible at this time.
- The individual refused to sign.
- Unable to communicate with the patient for the following reason:

Prepared By:_____Date _____