Virginia Pediatric Ophthalmology Specialists
Patient Demographics and Financial Consent

Date: _____/_____/_____ Chart: _____

Patient's Name: _____ Date of Birth: _____/_____/_____

Financial Policy:
VPOS will bill most insurance carriers for you when the proper paperwork is provided to us. Since your agreement with your insurance carrier is a private one, VPOS does not routinely research why an insurance carrier has not paid or why it paid less than anticipated for care. **If an insurance carrier has not paid within 60 days of billing, VPOS fees are due and payable in full from you.**

I hereby authorize payment directly to VPOS for medical services rendered. As the responsible party, I authorize the release of any medical records needed to obtain payment from my insurance company. I understand that as the responsible party, I will be responsible for the following (**you MUST initial each of these items in order to be seen in the clinic**):

_____Any balance outstanding regardless of insurance coverage
_____Any co-payment and/or deductible that is due at the time of service
_____To make this office aware of any insurance coverage change prior to my appointment to ensure that the insurance carrier you selected is the one which VPOS physicians are providers.
_____To obtain an insurance referral if required prior to my appointment – I will pay at the time of service in full in the event that a referral is not on file for the scheduled visit.
_____If any account is delinquent it will be turned over to a collection agency. I will be responsible for all costs of collection, including but not limited to collection fees or attorney fees plus court fees.

Refraction- the determination of the best corrective lenses to be prescribed, or a change in your glasses prescription (CPT Code: 92015) is a separate charge in addition to an eye exam. Most insurance companies consider this a "non-covered" or not "medically necessary" service.
_____ I understand that I am financially responsible for all services denied by my insurance company for these reasons.

THE PATIENT IS ULTIMATELY RESPONSIBLE FOR ALL PROFESSIONAL FEES.
I have read, understood, and agreed to the above financial policy for payment of professional fees.
Signature of Responsible Party: _____

Date: _____/_____/_____