Virginia Pediatric Ophthalmology Specialists, LLC
8700 Stony Point Parkway, Suite 210
Richmond, VA 23235
Patient Demographics

Date: ____/____/________ Chart: ________

Patient's Name: ____

Date of Birth: ____/____/________ Sex : ____ Martial Status: __________________

Address: ____

City: ___________________________ State: _____________ Zip Code: ________________

Home #: ___________________ Work #:__________________Cell#:__________________

Primary Care Physician: _____________________________ Phone: ___________________

Responsible Party- The Insured Adult

Full Name: ____

Insurance Policy Holders Date of Birth: ____/____/________ SSN: __________________

Employer: __________________________________ Work Phone:____________________

Cell Phone: ____________________

Address (If different from above): ____

City: _________________________ State: _______________ Zip Code: ________________

Emergency Contact: _______________________________ Relationship: ______________

Home #: ____________________ Work #: _________________ Cell #: ________________

Virginia Pediatric Ophthalmology Specialists

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 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 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 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 cost. **(33.3%)**

"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 for these reasons.

THE PATIENT IS ULTIMATELY RESPONSIBLE FOR ALL PROFESSIONAL Fees

I have read, understood, and agree to the above financial policy for payment of professional fees:

Signature of Responsible Party:____Date:_____/____/_______

HIPAA CONSENT FORM

HIPAA is the Health Insurance Portability and Accountability Ace of 1996.

Our Notice of Privacy Practices (NPP) provides information about how we may use and disclose Private Health Information (PHI) about you. You have the right to review our NPP before signing this consent. As provided in our NPP, the terms to our NPP may change, in accordance with change in Federal regulations. The current Federal guidelines may be obtained by viewing the link on our website, on this page.

You have the right to request that we restrict how PHI about you is used or disclosed. We are not required to agree to this restriction, but it we do, we are bound by our agreement.

By signing this form, you consent to our use and disclosure of PHI about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

If you have any questions, you may contact our Privacy Officer:

Nancy Lewis at 804-272-8040

Authorized Representative: ____

Relationship to Patient: ____