Virginia Pediatric Ophthalmology Specialists

Chart: _____

PATIENT INFORMATION

Patient Name: _____

Date of Birth: ____/____/_____ Sex: ____ Marital Status: _____ SSN:_____

Address: _____

City: _____ State: _____ Zip Code: _____

Home #: _____ Work #: _____Cell#:_____

Primary Care Physician: _____ Phone: _____

RESPONSIBLE PARTY- The Insured Adult - POLICY HOLDER

Person responsible for patient care

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: _____ Address:_____

Home #: _____ Cell #: _____

Patient Account Number: _____

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. 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 or check each of these items in order to be seen in clinic):

_____Any outstanding balance 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 obtain an insurance referral if required prior to 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. Therefore, the refraction is $50 and is to be paid in full at the time of the service is rendered. I understand that I am financially responsible for all services denied by my insurance for these reasons.

_____" ROUTINE" performed as part of a regular procedure (CPT Code 92004 & 92014; diagnosis codes H52.10 myopia, H52.229 regular astigmatism, H52.219 irregular astigmatism, H52.31 anisometropia, H52.4 presbyopia, H52.00 hypermetropia, rather than for a special reason. Most insurance companies do not cover 'routine" charges at VPOS since VPOS is considered a specialist. VPOS is currently in network with *most* Blue View/Eye Med vision plans, however you should check with your insurance carrier to determine if we are in network. Patients with VSP and Davis Vision plans would be responsible for the cost of the exam ($125) on the day of service. I understand that I am financially responsible for all services denied by my insurance carrier for these reasons.

_____Other materials, such as occluders or prisms, may be recommended and/or necessary as part of treatment. Most insurance carriers consider these materials as "non-covered" or "not medically necessary". Therefore, payment for these materials is due in full at the time of service. Occluders are $25 for a box of 50 and prisms are $50 for each prism. I understand that I am financially responsible for all services denied by my insurance carrier for these reasons.

_____ The return of a check (electronic or paper) issued to VPOS will result in a $25.00 returned check fee being placed on the patients account on whose behalf the check was presented for each returned check, no matter the reason.

<u>THE PATIENT IS ULTIMATELY RESPONSIBLE FOR ALL PROFESSIONAL FEES</u>

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

Signature of Responsible Party:

_____Date:_____/____/_____

Virginia Pediatric Ophthalmology Specialists

Patient Account #: _____

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: Lorraine Crowe at 804-272-8040

Authorized Representative: _____

Relationship to Patient: _____

INFORMATION REGARDING DILATING EYE DROPS

Dilating drops are used to dilate or enlarge the pupils of the eye to allow the ophthalmologist to get a better view of the inside of your eye.

Dilating drops frequently blur vision for a length of time which varies from person to person and may make bright lights bothersome. It is not possible for your ophthalmologist to predict how much your vision will be affected. Because driving may be difficult immediately after an examination, it's best if you make arrangements not to drive yourself.

Adverse reaction, such as acute angle-closure glaucoma, may be triggered from the dilating drops. This is extremely rare and treatable with immediate medical attention.

I hereby authorize Dr. Wortham/ Dr. Doerr and/or such assistants as may be designated by him/her to administer dilating eye drops. The eye drops are necessary to diagnose my condition.

_____

Patient (or person authorized to sign for patient) Date