PLEASE READ

I authorize treatment of the person named above and agree to pay all fees and charges for such treatment.

I understand if I have insurance and have provided accurate and complete information regarding my insurance, my charges will be filed with my insurance carrier, however, the financial responsibility for services rendered to a patient ultimately rests with the patient or responsible party. I understand that my copay and/or any coinsurance monies are due at the time of service. If I do not have insurance or my charges are not to be filed with insurance, payment in full is due at the time of service. In the event legal action should become necessary to collect an unpaid balance due for medical services rendered to me, I agree to pay all reasonable attorney's fees (33.33%) and any other court costs or costs of collection.

I hereby authorize assignment and payment directly to Retina & Vitreous Consultants of Virginia, P.C. major medical benefits due me for services provided by them.

Patient Signature	Signature Authorized Person	Date

HIPAA STATEMENT

I have read Retina & Vitreous Consultants of Virginia, P.C.'s ***Notice of Privacy Practices.***

I hereby authorize Retina & Vitreous Consultants of Virginia, P.C. to furnish, to my insurance company or authorize agency, information regarding my protected health information, for the purpose of treatment, payments or health care operations. I further authorize the physician(s) of Retina & Vitreous Consultants of Virginia, P.C. to consult as needed in their sole direction with other medical providers regarding my medical care.

I wish to place the following restrictions concerning the disclosure of my protected health information.

RETINA & VITREOUS CONSULTANTS OF VIRGINIA, P. C. can discuss my medical condition/information with the following:

	Yes	No		Yes	No
Spouse	☐	☐	Children	☐	☐
Parents	☐	☐	Friends	☐	☐

Please specifically list the names of friends that we may talk with: _____

_____

_____

Patient Signature	Signature Authorized Person	Date

RETINA & VITREOUS
CONSULTANTS OF VIRGINIA, P.C.

Diseases & Surgery of the Vitreous & Retina

Date _____

Patient Name: _____ Birthdate: _____

Address: _____ Home Phone: (_____) _____

City: _____ State _____ Zip _____ Work Phone: (_____) _____

Sex: ☐ M ☐ F Employed: ☐ Yes ☐ No Student: ☐ FT ☐ PT Patient SS # _____

Employer/School Name: _____

Responsible Party: _____

Referred by: _____ Family MD: _____

Person to notify in case of Emergency: _____

Relationship to Patient: _____ Emergency Phone: (_____) _____

Allergies: _____

INSURANCE INFORMATION:

PRIMARY INSURANCE CARRIER: _____ Phone: (_____) _____

Address: _____ ID# : _____

City: _____ State _____ Zip _____ Group #/Name: _____

Name of
Policy Holder: _____ Sex: ☐ M ☐ F Date of Birth ____/____/____

Policy Holder's Address: _____ Phone: (_____) _____

Policy Holder's Employer
or School Name: _____ Employer's Insurance Plan: ☐ Yes ☐ No

Relationship of Patient to Policy Holder: ☐ Self ☐ Husband ☐ Wife ☐ Child ☐ Patient ☐ Other

SECONDARY INSURANCE CARRIER: _____ Phone: (_____) _____

Address: _____ ID# : _____

City: _____ State _____ Zip _____ Group #/Name: _____

Name of
Policy Holder: _____ Sex: ☐ M ☐ F Date of Birth ____/____/____

Policy Holder's Address: _____ Phone: (_____) _____

Policy Holder's Employer
or School Name: _____ Employer's Insurance Plan: ☐ Yes ☐ No

Relationship of Patient to Policy Holder: ☐ Self ☐ Husband ☐ Wife ☐ Child ☐ Patient ☐ Other