Eye Doctor, MD, P.C.

Patient Name: _____ DOB: _____

CONSENT FOR TREATMENT
I authorize *Eye Doctor MD, PC* to provide medical treatment to myself and or my dependent.

ASSIGNMENT OF BENEFITS
I request that payment of authorized Medicare, Medicaid or applicable private insurance benefits be paid directly to Eye Doctor MD, PC for services provided under their care.

RELEASE OF MEDICAL INFORMATION
I authorize Eye Doctor MD, PC to release necessary medical information to my insurance company, its agents, or any third party payer in order for payable benefits for these services to be determined.

COLLECTION OF CO-PAYS AND DEDUCTIBLES
Per our agreement with your insurance carrier, you are required to pay any applicable copayments at the time of service. In addition, if you are insured with a high deductible insurance plan and have not met your deductible, we will collect $200 up front at the time of service.

FINANCIAL RESPONSIBILITY
I understand that Eye Doctor MD, PC will file my insurance claims as a courtesy; however, I am ultimately responsible for full payment of all charges. Should collection proceedings or other legal action become necessary to collect an overdue account, the patient or the patient's responsible party, understands that Eye Doctor MD PC 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 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 incurred by Eye Doctor MD, PC. I understand and agree that should Eye Doctor MD, PC be awarded judgment relating to this agreement or any debt incurred thereof, I will pay a service charge of one and one-half percent (1-1/2%) per month, eighteen percent (18%) per annum, beginning on the date of judgment.

REFERRALS/AUTHORIZATIONS
I understand if my insurance company requires a referral, I am responsible for obtaining a referral prior to my visit. If I do not have a referral I will be required to sign a waiver before being seen by the physician and payment in full for services rendered will be collected at the check-out desk.

MISSED APPOINTMENTS
We require at least 24 hours notice if you must cancel an appointment, failure to do so may result in a $25 "no show" fee.

RETURNED CHECKS
Our office will charge $25 for any check that is returned for insufficient funds.

I have read the above statements and I understand my responsibilities. I acknowledge that Eye Doctor MD, PC, will scan this document and destroy the original, and agree the scanned document is the same as the original.

_____ _____
Signature of Patient or Responsible Party (Date)

_____ _____
Printed Name of Patient or Responsible Party Relationship to Patient

Eye Doctor, MD, P.C.

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Refraction Form
The Refraction is the part of the eye exam when we determine your eyeglasses prescription ("Which is better, One or Two"). This is an essential part of any eye exam even if you do not plan to update your glasses. We recommend strongly that refraction be performed as part of any eye exam since it helps us determine your best corrected vision. In doing so, we can better assess the health status of your eyes.

Most insurance companies (including Medicare and Medicaid) do not cover the refraction fee. It is unfortunate if your insurance company chooses not to cover such an essential part of the exam nevertheless we urge you to undergo this important part of the exam. You are responsible for the refraction fee if your insurance company does not cover this service. The **refraction fee is $65.00** and it is due at the time of service. I have been notified by my physician that the services identified may not be a covered benefit by my insurance and payment is expected when services are rendered. I agree to be personally and fully responsible for payment.

_____ _____
Signature Date

E-Prescribing Form
ePrescribing is defined as a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. Benefits data are maintained for health insurance providers by organizations known as Pharmacy Benefits Managers (PBM). PBM's are third party administrators of prescription drugs programs whose primary responsibilities are processing and paying prescription drug claims. They also develop and maintain formularies, which are lists of dispensable drugs covered by a particular drug benefit plan. The Medicare Modernization Act (MMA) 2—3 listed standards that have to be included in an ePrescribe program. These include:

- I understand that Eye Doctor MD, P.C. may access the Virginia Prescription Monitoring Program (PMP) without specific patient consent
- **Formulary and benefit transactions—**Gives the prescriber information about which drugs are covered by the drug benefit plan.
- **Medication history transactions—**Provides the physician with information about medications the patient is already taking prescribed by any provider, to minimize the number of adverse drug events. By signing this consent form you are agreeing that Eye Doctor, M.D., P.C. can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payers for treatment purposes.

_____ _____
Signature Date

Referral Waiver – Required if your insurance requires a referral (HMO policy)
I did not bring a referral for the medical services I will receive today. If my primary care physician does not provide a referral, I understand that I am responsible for paying for the services I am provided.

_____ _____
Signature Date

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