EYE CARE & SURGERY, P.C.

PATIENT'S CONSENT FOR TREATMENT AND FINANCIAL RESPONSIBILITY

- I hereby authorize Eye Care & Surgery, P.C. to obtain/release information needed to process insurance claims, and/or to gather pertinent medical documents to ensure my safety. I authorize Eye Care & Surgery, P.C. to bill and to collect from my insurance companies. I hereby authorize the physicians and staff of Eye Care & Surgery, P.C. to perform and do hereby consent to such medical care as they feel is necessary, including diagnostic procedures, medical examinations, and treatments as may, in their opinion, be medically necessary. **I understand that I am ultimately responsible for all outstanding financial balances as well as collection fees generated from the pursuit of payment for such treatment delivered.**
- I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the result of any procedure, treatment, or examination.
- I request that payment of authorized Medicare and/or other insurance benefits be made on my behalf to Eye Care & Surgery, P.C. for any services furnished me by the physician and staff. I authorize any holder of medical information about me to release to any necessary entities and their agents, any information needed to determine these benefits or the benefits payable for related services.

CO-PAYS ARE DUE AT THE TIME SERVICES ARE RENDERED. We accept cash, checks, MasterCard, Discover, or Visa.

WE CANNOT GUARANTEE PAYMENT FROM YOUR INSURANCE COMPANY. ALL CHARGES ARE YOUR RESPONSIBILITY FROM THE DATE THE SERVICES ARE RENDERED. If your insurance is an **HMO** or managed care that needs a referral, **YOU ARE RESPONSIBLE FOR OBTAINING A REFERRAL FROM YOUR PRIMARY CARE PHYSICIAN.** Your referral must be in our office at the time of the visit.

_____Date_____
Patient's signature or Parent/Guardian (if patient is a minor).

Deemed Consent to HIV Testing: In case a health care worker of this clinic should be stuck by a needle or is directly exposed to fluids during your care which may transmit HIV virus, in accordance with Section 32.1 - 37.2 of the Virginia Code, you will be deemed to have consented to the clinic's right to draw blood for testing of the HIV virus and the release of such test results to the clinic and the worker who suffered the exposure.

_____Date_____
Patient's Signature or Parent/Guardian (if patient is a minor)