DRS. DOUGLAS AND VICTORIA M. WEISS, OPTOMETRISTS :: OFFICE POLICIES AND CONSENTS

www.weisseyes.com PHONE (434) 591-0262 FAX (434) 591-0111

Print Patient Name _____ Date of Birth _____ Today's Date _____

INSURANCE ASSIGNMENT AND RELEASE

Who is responsible for this insurance account? _____ Responsible party Date of Birth _____
Signature of the Responsible Party _____ Relationship _____ **Today's Date** _____
I, the undersigned, certify that I (or my dependent) have insurance coverage with _____and assign directly to Drs. Douglas and Victoria M. Weiss all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I further agree in the event of non-payment, to bear the cost of collection, and/or court costs and reasonable legal fees, should this be required. I understand that accounts with a balance over 60 days will be assessed 18% interest on the unpaid balance.
Beneficiary Signature _____ **Date of signature** _____

MEDICARE AUTHORIZATION (IF APPLICABLE) I request that payment of authorized Medicare benefits be made either to me or on my behalf to Drs. Douglas and Victoria M. Weiss for any services furnished to me by that doctor. I authorize any holder of medical Information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient responsibility only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.
Beneficiary Signature _____ **Date of Signature** _____□ NA

REFRACTION CHARGE: Refraction is the procedure in which the doctor determines the best corrected visual acuity of each eye for purposes of medical evaluation or for prescribing spectacles, contact lenses, or corrective surgery. For most insurances, including Medicare, there is no provision for coverage of this procedure, and there is no indication that it will likely become a covered service anytime in the near future. Refraction is necessary to adequately determine visual function and is important in making sure that serious underlying eye health problems do not exist. We perform refractions as a part of all of our comprehensive eye evaluations. We trust that you will understand the need to perform this procedure and respectfully ask for payment at the time of service.
The fee for refraction is **$35.00**. I have read and understand the prior information about refraction. **(Initials)** _____ **Date** _____

CONTACT LENS PATIENTS: Please be aware that the fitting or evaluation of contact lenses is performed in addition to your eye exam and there is a separate fee for this service. This fee is based on the type of contact lenses prescribed and the complexity of the evaluation or fitting process. **This fee may not be covered by insurance**. I have read and understand the above. **(Initials**)_____

DILATION CONSENT: Dilation examination of the retina is an important part of the ocular health testing. Drops are used to widen the pupil to get a more complete view of the peripheral retina. It is then possible to evaluate for the presence of retinal holes, tears, detachments, tumors, and circulatory changes in the retina. These conditions can occur without symptoms and cause visual loss without early detection and intervention. It is important for patients who are diabetic, hypertensive, or have heart or thyroid Conditions to have dilated exams regularly. Highly myopic patients and people who are not obtaining 20/20 vision, or have cataracts should have their eyes dilated as well. Patients with any family history of retinal disease or detachments or who are seeing floating spots or flashing lights should have their pupils dilated also. **PATIENTS WITH NEW SYMPTOMS OF FLOATING SPOTS / FLASHING LIGHTS SHOULD NOT WAIT TO COME IN AND HAVE THEIR PUPILS DILATED.**

Check One below:

- □ I accept dilation Date _____
- □ I would like to reschedule dilation Date _____
- □ I choose not to have my pupils dilated and release Drs. Douglas and Victoria M. Weiss or any other examining doctor in this office from any liability as a result of not having this test performed. Date _____

Signature of patient or legal guardian: _____ relationship _____ Date _____