Virginia Vision Associates

PATIENT FINANCIAL AND INSURANCE INFORMATION

Patient Name: _____ Today's Date: _____

If Minor, Parent's Name: _____ Sex: ☐ M ☐ F SS _____-_____-_____

Address _____ Date of Birth: _____

_____ Home #: _____ Cell #: _____

E-Mail Address: _____ Work #: _____

Emplolyer: _____ Occupation: _____

Emergency Contact: _____ Phone #: _____

updated to computer _____ initials

We would like to thank the person who referred you to our office. How did you hear about us? (friend, co-worker, family, yellow pages, insurance, etc.) _____

_____

****** *A NOTE TO ALL OUR CONTACT LENS WEARERS* ******

In most cases, contact lenses are not considered "medically necessary" by insurance companies. Any costs performed to determine or update a contact lens prescription may not be covered by most insurance companies and will be the responsibility of the patient.

Please list the person financially responsible for this account: _____

VISION INSURANCE: _____ Policy Holders's SSN _____-_____-_____

Policy Holder's Name: _____ ID# _____

Date of Birth: _____/_____/_____ Relationship to insured: _____ Group # _____

Address: _____ Phone #: _____

MEDICAL INSURANCE (for any **non-routine** care, i.e., eye infections, foreign body removal, etc.):
In order to insure a comprehensive ocular health examination, certain procedurs (such as retinal photography, visual fields, GDx, etc.) may be required, but MAY NOT be covered under your routine vision insurance. However, these procedures MAY be covered under your medical insurance, if medically necessary.

Medical Insurance Company: _____

Policy Holder's Name: _____ Policy Holders's SSN _____-_____-_____

Date of Birth: _____/_____/_____ Relationship to subscriber: _____ ID # _____

Address: _____ Phone #: _____

MEDICAL RELEASE AUTHORIZATION AND INSURANCE ASSIGNMENT:
I, the undersigned, authorize payment from my insurance company to be made to Virginia Vision Associates, PC/Larry N. London, OD PC, for covered services. I understand that I am responsible for obtaining any referrals necessary before my appointment or I must pay in full for that visit. Regardless of my insurance status, I am ultimately responsible for the balance on my account.

Should timely payments of this account not be made, I authorize Virginia Vision Associates, PC/Larry N. London, OD PC, to retain the services of an attorney and/or collection agency to assist with the collection of any outstanding balance. Any expenses incurred by such action shall become my responsibility.

I certify that the information I have provided with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information, to my insurance company in order to determine insurance benefits to which I may be entitled, this authorization may be revoked by myself at any time in writing.

_____ _____

Patient's Signature Date