**HRRC POLICY AGREEMENT**

**HIPPA Policy:** I have been provided the opportunity to receive and read a copy of Hampton Roads Retina Center Notice of Privacy Practices.

**Policy of Non-Discrimination:** Hampton Roads Retina Center does not and shall not discriminate on the basis of race, color, religion (creed), gender, gender expression, age, national origin, (ancestry), disability, marital status, sexual orientation, or military status, in any of its activities or operations. We are committed to providing an inclusive and welcoming environment for all individuals.

**Financial Policy:** For services rendered to me by Hampton Roads Retina Center, I authorize all payments and benefits provided by my insurance(s) be made to Hampton Roads Retina Center (HRRC). I authorize HRRC to disclose financial and medical record information to any agency involved in the payment for treatment and services performed by HRRC. I understand that I am responsible for all charges not covered by my insurance(s) to be paid in full. I understand that it is my responsibility to make all co-payments, deductibles, coinsurance and patient balance(s) at the time of my visit.

I understand that if my insurance requires a referral it is my responsibility to obtain one prior to my visit. If I have not received one prior to my visit, I will need to reschedule or sign a “visit without referral” agreement form; accepting responsibility of any costs incurred for the visit not covered by my insurance.

I agree to reimburse Hampton Roads Retina Center the fees of any collection agency, which may be based on a percentage up to a maximum of 50% of the debt, interest of 12% per annum, and all costs, and expenses, including reasonably attorneys’ fees that are in such collection efforts. I agree to pay a $25 charge for a “no show” fee for a scheduled office visit, if I do not cancel 24 hours in advance. I agree to pay a $200 charge for a “no show” fee for a scheduled surgical procedure, if I do not cancel 48 hours in advance.

Some patients in our practice require the administration of very expensive medications that are injected into the eye on a repeated basis. We must purchase these medications and wait for reimbursement from your primary insurance company. We expect prompt payment from your primary insurance company so that additional medications can be ordered in time for your next follow up appointment (generally 30+ days). If your primary insurance company has not made payment for a prior dose of medication by the time of your next injection; we require that you make a deposit by check/cash for the total amount. This will be returned to you upon receipt of payment by your primary insurance.

**Medicare Lifetime Beneficiary Agreement (Applicable to those insured with Medicare Part B):** I request payment of authorized Medicare benefits to me or on my behalf be paid to Hampton Roads Retina Center. I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

**Consent for use of Dilating Drops:** Dilating drops are used to dilate or enlarge the pupils of the eye to allow the ophthalmologist to get a better view of the inside of your eye. Dilating drops frequently blur vision for a length of time which varies from person to person and may make bright lights bothersome. It is not possible for your ophthalmologist to predict how much your vision will be affected. Because driving may be difficult immediately after an examination, it’s best if you make arrangements not to drive yourself. Adverse reaction, such as acute angle-closure glaucoma, may be triggered from the dilating drops. This is extremely rare and treatable with immediate medical attention. I hereby authorize Dr. Jon Adleberg and/or such assistants as may be designated by him/her to administer dilating eye drops. The eye drops are necessary to diagnose my condition.

**Use of Images for Educational Purposes:** I authorize Hampton Roads Retina Center the use of images taken of the back of the eye for educational purposes. Your identity can not and will not be identifiable or disclosed.

**SIGNATURE PAGE HRRC POLICY AGREEMENT**

**Patient Name (PRINT)** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**DOB**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***I have read, received and agree to Hampton Roads Retina Center Policy Agreement.***

Patient Signature/Legal Guardian ­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Disclosures to Family Members and Friends: *Listed below are individuals I authorize to discuss with HRRC about my medical and financial information.***

Patient Signature/Legal Guardian ­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: Relationship to Patient: Date: Date Revoked:

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| --- | --- | --- | --- |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**Minor/Child Consent (*if applicable*):**

I,\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(PRINT *parent/guardian name*) being the parent or guardian of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (PRINT *minor/child name*) do hereby request and authorize Hampton Roads Retina Center and staff to perform necessary services to my child which are deemed advisable by the physician, whether or not I am present at the actual appointment when the treatment is rendered. I may be reached during office hours at\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

Date:

**Patient Information**

First Name: MI: Last Name:

Date of Birth: SSN#:­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_ -\_\_\_\_\_\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: City/State/Zip:

Home Phone: Cell: Work: Ext:

Are you currently in a skilled nursing facility? Yes No

Are you currently under hospice care? Yes No

Race: Asian / Black / Hispanic / White / Other Preferred Language: English / Spanish / Other

Sex: Male/Female Marital Status: Single/ Married/Widowed/Divorced

Employer: Spouse Name: \_\_\_\_\_\_

Referring Dr.: Primary Care Dr.:

Primary Eye Dr.: Location of Eye Dr.:

**Emergency Contact**

Name: Relationship:

Address: City/State/Zip:

Home Phone: Cell:

**Tricare (If applicable)**

Sponsor Name: \_\_\_\_\_ Sponsor SSN#:­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_ -\_\_\_\_\_\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sponsor Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_