

Patient Information Form
Fairfax Optometric Center
10721 Main St., Suite 2400
Fairfax, VA 22030

Patient's Name _____
Last, First, Initial

Telephones
(H) _____

Address _____

(C) _____

City _____

(W) _____

State _____ Zip _____

Preferred _____

Medical Insurance Carrier _____

Date of birth _____

Subscriber _____

SS# _____

Relationship _____

Employer _____

Subscriber Date of Birth _____

Marital status S M W D

Subscriber ID _____

Name of Spouse _____

Secondary Insurance yes _____ no _____

Vision Service Plan yes _____ no _____

Insurance and Financial Policy Information, Agreement, and Authorization

Fairfax Optometric Center (abbreviated as FOC) accepts many, but not all insurance plans. FOC is not responsible for referrals. Patients will receive an itemized statement for submission to insurance plans which FOC does not accept. Payment is expected at the time of each visit. Returned checks will be subject to a \$40 returned check fee. All patients must present complete insurance information at the time of service to be eligible for benefits through FOC. Patients will notify FOC of any changes to their personal or insurance information. Retroactive insurance claims cannot be submitted by FOC. Statement sent to patients will be expected to be paid within 30 days of statement date. Unpaid statements will be placed with a collection agency or an attorney and subject to interest of 1.5% per month and to additional collection/attorney's fee. The patient is responsible for non-covered services and for charges denied by his insurance company for services not paid within 60 days.

I understand and agree to comply with this office financial policy.

I authorize FOC to apply for benefits on my behalf for covered services rendered by FOC. I request payments from my primary and secondary insurances to be made directly to FOC. I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claim to the above named billing agent. I permit a copy of this authorization to be used in place of the original. In all insured assigned cases, the physician or supplier agrees to accept the charge determination of the insurance carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and deductible are based upon the coverage determination of the insurance carrier.

FOC agrees to provide optometric services to the undersigned.

Signature of Patient/Guardian

Date

Signature of Staff/Employee

Date

