

Name:

Chart:

Date:

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### INSURANCE WAIVER

Date: \_\_\_\_\_

Patient: \_\_\_\_\_

#### **Self - Pay Patients Only**

- I choose to be seen without insurance coverage and pay for the cost of today's medical services myself.

\_\_\_\_\_ signature

#### **HMO Plans**

I did not obtain the referral needed to have my insurance carrier process a claim for today's visit.

I understand that I may reschedule my visit and obtain a referral to be seen at a later date.

##### For Visits Without Referrals

- I will attempt to obtain a valid referral dated with the date of service from my primary care provider. The referral should be faxed to NVOA billing office at 703-237-8923 within two business days. If a valid referral is not received, I understand that a claim will be filed to the insurance carrier with a referral waiver attached and I will be responsible for the cost of today's medical services myself.

Date: \_\_\_\_\_ Procedure: \_\_\_\_\_ Cost: \_\_\_\_\_

\_\_\_\_\_ signature

#### **POS Plans**

- My insurance policy has a "Point of Service" (POS) benefit which I choose to use and request that Northern Virginia Ophthalmology submit a claim on my behalf under my POS benefits with the understanding that my out of pocket expenses may be greater than submitting a claim with a referral.

\_\_\_\_\_ signature

#### **Open Access Plans**

- My "Open Access" does not require a referral and request NVOA to submit a claim on my behalf under my open access benefits with the understanding that I am responsible for any expenses deemed as patient responsibility.

\_\_\_\_\_ signature

#### **Routine Exams**

- I choose to use my one routine vision care benefit for today's appointment. If I am not eligible for routine eye care services through my insurance provider, I will be responsible for all charges incurred.

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