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Diseases and Surgery of Retina, Vitreous, and Macula

1) DEEMED CONSENT FOR DESIGNATED BLOOD-BORNE PATHOGENS

If a healthcare worker is exposed to your blood or body fluids, testing may be performed on a sample of your blood to determine the presence of hepatitis B or C and HIV (human immunodeficiency virus) which causes AIDS (acquired immunodeficiency syndrome). The policy in effect at Virginia Retina Consultants (VRC) is in accordance with the Virginia Acts of Assembly Section 32.1-45.1.

This policy applies when any healthcare worker associated with or working for VRC is directly exposed to a patient's blood or body fluids in a manner which, according to the guidelines of the Centers for Disease Control, may transmit HIV or hepatitis B or C. Upon such exposure, VRC is required to notify you that this testing will occur. Testing the patient may be conducted by the patient's personal physician. Testing of the exposed VRC employee may be conducted by the employee's personal physician. The results will be made available to the patient, VRC, and applicable health authorities and will otherwise be kept confidential.

I acknowledge that I have read and understand this consent and that I have been given an opportunity to ask questions. **INITIALS** _____ DATE _____

2) FINANCIAL POLICY

IF YOU HAVE INSURANCE: We need a copy of your current and valid insurance card. We will be happy to process your insurance claim for reimbursement. **You will be required to pay any copayment and/or deductible stated by your insurance carrier at the time of service.**

We will gladly discuss your proposed treatment and answer any questions related to your insurance. You must realize, however, that you are responsible for paying your account balance whether or not your insurance company pays. We must emphasize that our relationship is with you and not the insurance company.

CASH PATIENTS: You are responsible for payment at the time of service. Verbal and/or additional written payment arrangements will need to be made with our accounts manager prior to consultation and treatment.

WORKERS' COMPENSATION: You are responsible for notifying us prior to treatment that your visit results from a work-related injury.

Returned checks are subject up to a $50 fee.

I acknowledge that I have read, understand, and accept the above financial policy:

Patient or Representative Signature: _____ Date: _____