Dr. Clifford Roffis & Associates, ODPC

4811 S. Laburnum Ave. Henrico, VA 23231
Phone 804.226.1144 Fax 804.236.9026

Patient Name _____ ❑ Married ❑ Single ❑ Widow ❑ Child ❑ Other

❑ Male ❑ Female Date of birth _____ / _____ / _____ SSN # _____

Employed? ❑ Full-time ❑ Part-time ❑ Retired ❑ Student ❑ No If yes, employer _____

Billing Address _____

City _____ State _____ Zip Code _____

Home # _____ Daytime # _____ ***Cell #***_____

Email _____

Wellness Image

We are pleased to announce Optos, a new technology for capturing an image of the retina that never touches your eye and takes just seconds to capture. This image will be kept in your records for future reference.
A Wellness image can sometimes be done in place of dilation. Many of our patients return to work, school, or activities with ease and without hours of blurred vision and sensitivity to light.
*** As always, it is the doctor's discretion and you will be informed if dilation or any other medical testing is needed. ****

_____ Yes, I would like a Wellness Image at the rate of **$39.00** due the date of service

Insurance Authorization & Acknowledgment of Notice of Privacy Practices

- I authorize the release of information including diagnosis and records of treatment or examination to third party payers or health practitioners and I authorize payment to Dr. Clifford Roffis ODPC for services rendered during my visit.
- I acknowledge that the HIPPA Privacy Notice has been made available and will be notified if any changes are made.

Please Read and Initial **Payment Policy**

_____ I understand that it is my responsibility to provide up-to-date insurance information including any referrals needed. **A Pre-authorization DOES NOT GUARANTEE PAYMENT** and I am responsible for charges incurred due to co-pays, deductibles, co-insurance, insurance denials and/or any other reason.
NOTE: Insurance providers require a copay, if applicable, to be collected for **EVERY** visit.

_____ Balances on my account, for any reason, must be paid **BEFORE** any RXs, materials, or records can be released. Should my account be turned over to the collection agency; I agree to pay all related costs incurred in this process. Returned checks are processed by Check Xchange. The check will be reprocessed up to two times in an attempt retrieve the original check amount and a $50 reprocessing fee will be taken from the account as well.

_____ Contact Lens Evaluations are done every year to insure the health of the eye. This fee is due **BEFORE** services are rendered and must be done within 60 days of the routine exam date. **NO EXCEPTIONS.**
Opened boxes of any sort; in office or online, are **NON-REFUNDABLE.**

_____ **Eye Glass purchases** are **NON-REFUNDABLE** and **Frames CANNOT** be **exchanged. NO EXCEPTIONS.**
All materials purchased must be picked up within 30 days of the order date. Materials returned to stock are subject to restocking fees and any **deposits made are NON-REFUNDABLE.**

Patient / Guardian Signature _____ Date _____

If you are signing as a *personal representative* of the patient, please give your name and relationship to the patient.

Print Name _____ Relationship to Patient _____