



Patient Responsibility Agreement

At Northern Virginia Center for Eye Care, we want to make the patient experience exceptional. While we do our best to make this happen, we ask for your understanding that the following policies have evolved to keep us efficient and to provide you with the highest quality of care:

1. Patients must verify demographics and provide their current insurance card(s) at every visit.
2. Patients are responsible for verification of insurance coverage.
3. Patients must pay any outstanding balances prior to scheduling any future appointments.
4. Financial Responsibilities:
 - I am financially responsible for my deductible, coinsurance, or non-covered service(s). I understand co-payments are due at the time of service.
 - If my insurance plan requires a referral, I must obtain it prior to my visit.
 - I agree to pay for charges that are not covered by my health plan.
 - If I am uninsured, I agree to pay for the medical services at the time of service.
5. There may be fees associated with:
 - Cancellations within 24 hours of the appointment(s)
 - Lost glasses/contact lens/medication prescriptions
 - Medical record requests
 - Completing forms (i.e. DMV)
6. **Patients must be respectful to our office staff and Doctors. We do not tolerate disruptive or threatening behavior.**

I understand the above policies _____
Signature Date

Name (Printed): _____