Submit Form Print Form

You have been referred to the VMR Institute

- Our physicians specialize in diseases and surgery of the vitreous, macula and retina.
- Please complete the "New Patient Information Form" and submit or bring it with you.
- Please bring your current insurance identification card(s) and a photo I.D.

MEDICAL ASPECTS

- Your visit may last 1 - 3 hours, depending upon the specialized tests or procedures required.
- Please bring your current medications with you to your appointment.
- If you have ***diabetes***, please be sure to eat your regular meal or bring a snack.
- Before seeing the doctor, you will be evaluated by an ophthalmic technician who will dilate your pupils. Pupil dilation will make it difficult for you to see at near, but your distance vision should be adequate to drive, if you so choose. It may be advisable to bring a driver. We do advise that you bring your sunglasses.
- The effects of dilation usually wear off in a few hours; however, they may last overnight.

FINANCIAL POLICY

We feel it is important that you are aware of the financial policy of this office. If you have health insurance, **it should be understood that this is a contract between you and your insurance company (not this office)**, to pay for medical care. Prior to any treatment, you are encouraged to ask about the fees and compare them with your insurance company's fee schedule. Approval or prior authorization is a declaration by your insurance company the specified services are medically necessary; not a guarantee of payment. You are responsible for your care. **Thus, you will be billed directly for any service/claim not paid within 45 days. You may seek direct reimbursement from your insurance company.**

As a courtesy to our patients, we will be pleased to complete and submit the medical claim form (CMS-1500) for healthcare services.

- **MEDICARE PATIENTS:** We are Medicare participating providers. You are responsible for your annual deductible and the co-insurance. We will bill Medicare and one supplemental plan. If the supplemental plan has not paid within 45 days, payment will be due and payable by you. You may seek direct reimbursement from your insurance.
- **IPA PATIENTS:** We are contracted with several IPA plans and medical groups. Authorized services are billed directly to the medical group; however, you are responsible for your office visit co-payments. **If you change health plans, medical groups or primary care physicians, please inform us prior to your visit and before you receive any medical services as this may invalidate your authorization and you will be responsible for the payment at the time of service.**

- **CO-PAYMENTS:** Please be prepared to pay your co-pay when checking in at the front desk.
- **PPO/EPO/GROUP INSURANCE:** We are participating providers for most major health plans. Any deductibles and co-payments are collected at the time of service. As with any other credit account, payment is required every month regardless of pending insurance claims.
- **DISABILITY FORMS:** There is a $15-$45 processing fee per form) depending on complexity, payable when the form is brought to the office. **Please allow 3-5 business days for the forms to be completed.**
- **RETURN CHECK FEES:** $25.00 for any reason.
- We accept cash, personal checks, MasterCard, Visa, Discover and American Express.
- Should you decide to pay by credit card, you authorize this office to disclose to your credit card company your information, i.e., the credit card being used, the expiration dated and name as imprinted on the card, and on occasions when identity verification is required, your billing address. This is the information required to run a charge through our credit card machine.

INITIALS _____

CANCELLATIONS MADE WITH LESS THAN 24 HOURS NOTICE MAY BE SUBJECT TO A $50 CANCELLATION FEE.

If you have any questions pertaining to this financial policy, please do not hesitate to ask. We will be happy to assist you.

Thank you.

J. Sebag, M.D.

Founding Director & President

VMR Institute, A Medical Corporation

"I, the undersigned, realize that all medical and surgical charges incurred are my financial responsibility and hereby authorize VMR Institute to bill my insurance on my behalf. I hereby authorize the release of medical information to my health plan, or its intermediaries, any information needed for this or related claim. A photocopy of this document shall be valid as the original.

I HAVE READ THE FINANCIAL POLICY AND AGREE TO ABIDE BY ITS TERMS AND FURTHER ASSIGN INSURANCE BENEFITS TO BE PAID DIRECTLY TO VMR INSTITUTE, A MEDICAL CORPORATION.

PATIENT'S SIGNATURE _____ **PRINT NAME** _____

PARENT/GUARDIAN'S SIGNATURE _____ **DATE** _____