Authorization to Give Consent for Outpatient Medical Treatment

Child / Patient Name: ______________________________________ Date of Birth:_____________________

Until revoked by me in writing, the following persons are authorized to act on my behalf:

- To give consent to medical and diagnostic treatment in Virginia Pediatric Eye Center (VPEC) physician offices of my child named above;
- To give consent for testing my child's blood for HIV antibodies in accordance with the laws of Virginia which authorize healthcare providers to test patients when a healthcare provider is exposed to the body fluids of a patient;
- To assign benefits of third party payers for direct payment to VPEC; and
- To receive financial information regarding my child's health care and/or medical information about my child's condition, treatment, or health care received at VPEC.

I agree that the following persons, 18 years of age or older, are authorized to sign on my behalf thus acknowledging the following statement and binding me to its terms in my absence: The undersigned parent and/or legal guardian agree that in consideration of service rendered to the patient, each of them jointly and severally, will pay and guarantee payment to VPEC. I furthermore irrevocably direct and assign payment from my insurance company, Medicaid, Medicare, Tricare, or other provider of health care benefits to VPEC for services rendered. I understand my insurance policy is a contract between my insurance company and me, and I am responsible to VPEC for any charges not covered by my insurance, including co-payments, deductibles, and fees for non-covered services. If all charges are not paid when due to VPEC, the undersigned agrees to pay all costs of collection, including collection agency and attorney's fees in an amount not to exceed THIRTY PERCENT (30%) of the balance placed with agency and attorney, which shall be deemed incurred upon referral.

Once payment has been received from my insurance company, any balance remaining on my account will be payable by me upon receipt of my statement. Co-payments and other self-pay amounts are due prior to leaving the office. I have been informed that a fee of $35.00 may be applied to my account for returned checks. The RETURNED CHECK FEE is only payable in cash or money order. Please direct all billing inquiries to the VPEC Billing Representative.

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First Name MI Last Name Relationship to Child

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First Name MI Last Name Relationship to Child

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First Name MI Last Name Relationship to Child

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Signed by Parent / Legal Guardian: Date