# The Retina Group, Inc.

**PATIENT FINANCIAL POLICY**

We are committed to providing you with the best possible medical care; if you have special needs, we are here to work with you. The following information is provided to avoid any misunderstanding or disagreement concerning payment for professional services.

1. Our office participates with a variety of insurance plans. It is your responsibility to:
   1. Bring your insurance card(s) to every visit and make us aware of any changes in your coverage.
   2. Be prepared to pay your co-pay at each visit. Payment can be made by cash, check, or credit card (Visa, MasterCard, Discover, and CareCredit). We are required by your insurer to collect this payment.
   3. For medical care not covered under your insurance, payment in full is due at the time of the visit
2. If you have an insurance that we do not participate in, our office is happy to file the claim upon request. However, payment in full is expected at the time of service. This also applies to uninsured patients.
3. It is your responsibility to obtain required referrals or authorizations for treatment prior to your visit. If you do not have the referral or authorization, your visit may be rescheduled in non-emergency circumstances or you may financially responsible.
4. If the patient is a minor (*under the age of 18*), the parent or guardian must sign below. The parent, guardian, or unaccompanied minor is responsible for payments due at the time of service, providing necessary referrals, authorizations, and insurance card(s). If a parent is responsible for any balances, we will ultimately rely upon the parent who brought the child to the office as being financially responsible.
5. If you have questions about your insurance, we are happy to help you. Specific coverage issues, however, should be directed to your insurance company's member services department (this number can be found on your card).
6. If you fail to make payment in full for services that are rendered to you, your outstanding balance may be reviewed for collections. You will be responsible for fees assessed by collection agency.

Our practice firmly believes that a good physician/patient relationship is based upon understanding and good communication. Questions about financial arrangements should be directed to our billing department at:

(614) 464-3937. Please sign that you have read and agree to this Financial Policy.

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Signature of Patient or Responsible Party Date

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Signature of Co-Responsible Party Date

**APPEAL REPRESENTATIVE FORM**

Member Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Member DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Member ID Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, appoint The Retina Group, Inc. to act as my representative in requesting appeals from my health insurance company regarding the termination, reduction, denial, underpayment, or suspension of medical service coverage.

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Signature of Patient or Authorized Representative Date

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Print name of Individual’s Representative (if applicable) Relationship