Billing Authorization

Please read and sign this form prior to your appointment.

Insurance

We participate in many insurance plans. If you are not insured by a plan we do business with or do not have an up-to-date insurance card, payment in full is expected at each visit. When you provide us with current and complete information we bill primary and secondary insurance. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you. Please contact your insurance company with any questions you may have regarding your coverage.

Payment

All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. You may pay by cash, check and credit/debit cards.

Non-Covered Services

Please be aware that some of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers.

Patient Acknowledgement and Authorization

I accept financial responsibility for all payments and for services received. I authorize Retina Care Center to send copies of my records to other physicians as needed for continuity of care.

I authorize Retina Care Center to bill my insurance for services provided, and to make available any information needed to process my claim. I assign all insurance and/or Medicare benefits to Retina Care Center for services provided by them. This assignment will remain in effect until revoked by me in writing.
A photocopy of this assignment is to be considered as valid as this original.

I acknowledge that I have received a copy of this organization's Notice of Privacy Practices (HIPAA).

Signature: _____ Date: _____