Retina & Vitreous, LLC

Financial Policy

We are committed to providing you with the best possible medical care. We are willing to work with you if you have special financial needs. Our practice firmly believes that a good physician/patient relationship is based upon understanding and communication.

Please bring your **medical** insurance card(s) with you for each visit. We do not bill to vision insurance.

It is your responsibility to provide **current** insurance cards at time of service, you may be responsible for the charges if you do not provide them to us in a timely fashion.

In order to prevent fraud, you will be asked to provide a valid US government issued photo ID at your first visit. **Attention: we will not be able to see you without a valid photo ID.**

Our office participates in a variety of insurance plans. It is important for you to verify if our doctors are providers in your plan.

It is your responsibility to get a referral if your insurance requires one. If you do not get a refferal, you will be responsible for **all** charges and considered a self pay patient. Copay is due at time of service.

Commercial Patients-In Network

You agree to pay your copay at time of service. You agree to pay any coinsurance or deductibles that your insurance states to us is patient responsibility.

Out of Network Commercial Patients

You are considered a self pay patient in this office and the self pay policy will apply to you.

Self Pay Patients

A deposit of $350.00 is required at your first visit. Your charges that day may be more, based on diagnostic testing or any treatment.

Medicare Patients

Please bring a copy of your Medicare card, your supplement card, and your drug card.

We will file with Medicare and the supplement and agree to accept Medicare's assignment for our fees. Any amount we bill you is after your insurances have paid their portion and have informed us of what to bill you. You agree to pay your portion.

If you have a replacement plan for Medicare, we will need a copy of that card. This replaces

your Medicare card. **Many replacement plans have a copay which you agree to pay on your date of service** and additional out of pocket coinsurance for procedures and diagnostic testing. You will be responsible **also** for this portion that your plan puts as patient responsibility.

For patients 17 years and younger, a parent or guardian must accompany them and sign below (exception: declared emancipated minors). It is the parent's or guardian's responsibility to provide insurance cards and payments at time of service.

I request that payment of authorized insurance benefits be made on my behalf to retina & Vitreous, LLC for services rendered to me by Dr. Robert Lee.

I authorize any holder of medical information about me to release any information needed to determine these benefits or the benefits payable for related services. I also understand that I am responsible for my portion of all medical fees explained in this financial policy.

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Signature of Patient or Responsible Party **Today's date**