Alliance
Retina

NOTICE OF FINANCIAL POLICY

Please read and sign the following financial policy summary. If you have questions about our Financial Policy, please contact Management at 817-617-7678.

1. All Co-Pays, Coinsurance, Deductible amount required by your insurance company must be PAID at the time services are rendered. Though we do our best to verify your insurance benefits, the quoted amount is only an estimate provided by your insurance website or representative. Benefits cannot fully be determined until the claim has been submitted for review & processing. Any balances remaining, after the claim has been submitted and any payments received from the plan, will be the responsibility of the Patient/Guarantor. Before getting services, it is your responsibility to check your provider's network status and review the insurance plan benefits including any co-payment, coinsurance, or deductible obligations PRIOR to the appointment.

2. Please be prepared to provide our office with a copy of your insurance card(s) and picture identification every time you visit our practice. This allows us to file your insurance claims correctly. It is the patient's responsibility to notify our office of any insurance changes PRIOR to your visit. You may be responsible for any services or treatments provided if our office was not made aware of the new insurance plan PRIOR to your visit.

3. If you have a managed care insurance plan (HMO), your insurance may require a PCP referral for the current date of service. It is the patient's responsibility to obtain any authorizations or referrals necessary to see our physicians. Unauthorized services or treatments will be the patient's responsibility. Prior authorization approval also does not guarantee that the plan will pay for the services. This could result in the member/patient being held liable for any unpaid balances or uncovered services, determined by the payer, for the date of service in question. Before getting services, it is your responsibility to check your provider's network status and plan requirements.

4. Billing statements will be sent monthly after your insurance has been processed and we have posted the appropriate items to your account. Insurance payment is based on the submitted claim, the actual health care services you received, the medical necessity of the services received, and the coordination of benefits. This could result in the member/patient being held liable for any unpaid balances or uncovered services, determined by the payer, for the date of service in question. Before getting services, it is your responsibility to check your provider's network status and plan benefits. Our physicians are not responsible for any services or medications not covered by your insurance plan.

5. Financial responsibility for a minor is the responsibility of the accompanying adult unless arrangements have been made prior to the visit.

6. Any PAST DUE BALANCE is required to be paid either by the statement received from our billing office or at the time of your next visit. In the event your account is past due, we will take the necessary steps to collect the debt, and possible referral to a collection agency that could affect your credit record. Each time you visit our office you may be required to update your personal information such as home address, contact phone numbers, and emergency contact phone numbers.

7. SELF PAY/CASH PAY POLICY: For patients who are using cash for their office visit, a PAYMENT IN FULL will be due at the time of service, unless other payment arrangements have been made with our billing department.

8. For physician affidavit letter, FMLA, disability, or other leave-related paperwork, there will be a minimum of $25.00 fee to complete such forms. Please refer to our Medical Record Policy for fees and other related questions.

9. For medical record request, there will be a minimum of $25.00 to complete such request. Alternatively, you may access the patient portal to view all clinical notes at no charge. Please refer to our Medical Record Policy for fees and other related questions.

10. Physician surgical fees owed are due PRIOR to any surgery performed by the doctor(s) in the various facilities we perform surgery in. This would include any deductible, copay, or coinsurance. Fees quoted by our office for surgery are for the SURGEON ONLY. The facility where the operation is performed is responsible for quoting and collecting payment for their fees. It is your responsibility to contact the surgery facility to obtain their fees and make payment arrangements PRIOR to the date of surgery.

11. We accept cash, checks, and all major credit cards. Post-dated checks will not be accepted by our office. A returned check fee will be assessed on all returned bank items and could inhibit your ability to pay with that method in the future.

By signing this form, I acknowledge I have read Alliance Retina Financial Policy disclosure and understand all of its content. I understand that I may ask any questions before signing the disclosure. I also may request for a signed copy of this written notice at any time.

_____ Date: _____

Patient Signature

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Patient Printed Name