

**Brown Retina Institute
Patient Responsibility Payment Policy**

Thank you for choosing our practice. We are committed to providing the best possible care. The following information is provided to avoid any confusion regarding payment for our professional services. Please sign below that you have read and agree to this Policy.

PLEASE PRESENT INSURANCE CARD AT THE TIME OF VISIT

Payment Policy

- We accept cash, check, Visa, MasterCard, Discover and American Express.
- At the time of your visit, you are responsible for paying your co-pay and any deductible not met. If these charges are not paid on the date of service, a \$25.00 fee may be added to your account.
- Your insurance company requires us to collect your co-pays and deductibles.
- All fees are based on the type of service provided for your care, and related services. It is your responsibility to know what is covered by your insurance. We must file each visit based on both the reason a patient is seen and any diagnoses made at the exam.
- If the patient is a minor (18 years old and younger), the parent or guardian is responsible for applicable fees.
- For any non-covered services, payment for all charges is due at time of service.
- If your account is more than 90-days overdue, it will be considered delinquent. If you write a check and it is returned, a \$30 collection fee will be added to your account.
- For High Deductible policies (including patients with Health Savings Accounts), payment will be collected at the time of service (except in rare circumstances where benefit requires filing claim first) and any contracted discount fees will apply.
- Appointments cancelled or missed with less than 24 hours notice will be charged a fee of \$25.

Insurance

As a courtesy, we will file your insurance. However, it is your responsibility to know your benefits, to notify this office of any changes to your insurance for coverage, and to pay any amount that is determined to be your responsibility. If we are unable to verify your insurance for coverage or authorization for services, you will be responsible for any charges incurred. Your insurance policy is a contract between you and your insurance company. We are not a party to this contract. If your insurer has not paid within 45 days from filing, you will be billed for the entire amount even if the claim is being appealed. If an appeal is necessary, we will appeal your claim one time only. It is your responsibility to contact your insurance company if payment has not been made, although we will help provide any information required from our office.

Forms

We will gladly complete one medical information form free of charge each year. After the first form, each additional form will be completed for a charge of \$20. (must be paid at time of request and please allow up to two weeks for completion). Forms required by your health insurance company will be completed without charge.

Acknowledgement and Authorization

I have read, understand and agree to the above Payment Policy. I understand that any charges not covered by my insurance company are my responsibility.

I authorize my insurance benefits be paid directly to Brown Retina Institute.

I authorize Brown Retina Institute to release any medical or other information to my insurance company when requested.

Signature

Date

Printed Name