To help achieve our goal of providing the best medical care possible, we ask for your understanding and cooperation regarding the following payment policies.

Payments

An insurance plan is a contract between a patient and their health insurance company. It is the patient's responsibility to know their benefits and the limits of their coverage. *We ask that payments, including copayments and applicable deductibles, be made at the time of service.* For your convenience, we do accept checks, money orders, debit cards, and most major credit cards. *We do not accept cash.*

Self-pay Accounts

Self-pay accounts are for patients without insurance coverage, as well as patients covered by insurance plans in which our office does not participate. It is the patient's responsibility to know if our office is participating with their health plan. Self-pay patients will be required to pay up front for all services performed.

Workers' Compensation

It is the patient's responsibility to provide our office staff with contact information regarding a workers' compensation claim, at the time of service. Any charges denied by workers' compensation will then become the patient's responsibility.

Overdue Balances

When a balance is due, the patient will be sent four statements, one per month. Each month that the balance remains unpaid, *a $15.00 late fee will be added to the balance*. If payment has not been received within the 120-day period, the patient will be dismissed from the practice and the unpaid balance may be turned over for collections. Unpaid balances which are sent to collections will incur additional fees, as the patient will be held responsible for all collection costs.

I hereby authorize Advanced Retina & Eye Cancer Center to apply for reimbursement benefits on my behalf for services rendered to me. I understand that payment from my insurance carrier will be made directly to Advanced Retina & Eye Cancer Center. I further authorize the release of any information necessary to process any claim with my insurance carrier. I understand that I am financially responsible for all charges not covered by my health insurance. I further understand that I will be responsible to pay for any service denied by my insurance company.

I have read and understand these payment policies and agree to abide by the guidelines.

________________________________ ________________

Patient/Guardian Signature Date