# Retina Associates of Kentucky

## Patient Financial Policy

At Retina Associates of Kentucky we are committed to providing you with the best possible care and are available to discuss our professional fees with you at any time. You are responsible for seeing that the entire bill is paid in full. Retina Associates is contractually obligated to all insurance companies to collect on balances that are your responsibility. Your clear understanding of our financial policy is important to our relationship. If you have any questions about this policy, we encourage you to contact our billing department.

**Insurance:** Billing insurance is a courtesy we provide our patients. Our professional services are rendered to a person, not an insurance company. The insurance company is responsible to the patient and the patient is responsible to us. Therefore, if your insurance does not respond within 30 days the bill will become your responsibility. Please notify us if your insurance carrier or policy has changed. If your insurance plan determines that a service is not covered for any reason you will be responsible for payment of the charges. If you do not bring a current and valid insurance card to your visit and/or we cannot verify your insurance coverage, you must pay a deposit at check in and the balance of charges in full that day at check out. If you do not pay the deposit at check in, your appointment will be cancelled and rescheduled at your request.

**Copayments, Deductibles and Co-Insurance:** Retina Associates will verify your insurance benefits and you will be expected to pay your portion at the time of service.

- If you have insurance that requires an office copay, you must pay the copay at check in. If you cannot pay your copay at check in, your appointment will be cancelled and rescheduled at your request.
- If you have a high deductible insurance plan, you must pay a deposit at check in. If you cannot pay the deposit at check in, your appointment will be cancelled and rescheduled at your request. You must also pay 50% of the charges at check out, less any amount paid at check in.
- Medicare pays 80% of medical claims after your deductible has been met. If you do not have a secondary insurance, you are responsible for your 20% co-insurance at check out.
- A deposit may be required prior to the date of service for surgery appointments.

These guidelines may be waived if you are being seen for an emergency where a delay in care would threaten permanent damage to your eye.

**Non-Participating Insurance Plans or "Out of Network":** It is your responsibility to verify whether Retina Associates of Kentucky contracts with your insurance plan. Any outstanding balances are your responsibility.

**Referrals:** If your insurance plan requires a referral, it is your responsibility to obtain this prior to your appointment and have it with you at the time of the appointment. If you do not have your referral you may be required to reschedule the appointment or sign a waiver stating you do not have the necessary referral form and assume total financial responsibility for services that day.

**Workers Compensation/Other Accident Cases:** In order for Retina Associates to file a claim with your workers comp or other liability carrier, you must provide complete billing information. Without this information, we are unable to bill your insurance carrier and we will ask for payment in full at the time of service. You will be financially responsible for medical services related to work comp/accident if insurance fails to pay in full. Retina Associates will not bill attorneys for medical expenses.

**Self-Pay:** Payment in full is required at the time of service. A deposit is required prior to being seen and the balance will be collected at check out. If you do not pay a deposit at check in, your appointment will be cancelled and rescheduled at your request. A discount will be applied to all charges paid in full on the day of service and not billed to insurance. If you acquire retroactive insurance at a later day, you may submit your receipt for services to your insurance company for reimbursement by your insurance company. These guidelines may be waived if you are being seen for an emergency where a delay in care would threaten permanent damage to your eye.

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**Minors of Divorced Parents and Child Custody Cases:** Both parents or legal guardians are financially responsible for care rendered to minor children. We do not get involved in divorce situations and the parent that signs for the child will be financially responsible and any statements will be mailed directly to that parent.

**Post-Operative Surgery Charges:** Following most surgical procedures, related office visits are included and will not be charged during the post-operative period. Services such as diagnostic testing or exams and procedures for the other eye will be charged separately during this time and you will be responsible for any copays or coinsurance assigned by your insurance company.

**Outstanding Balances:** A statement will be mailed to you for any unpaid amount indicated as patient responsibility by your insurance company. No statement will be mailed to patients who have a balance less than $15, however you are still responsible for the paying the account balance at the next visit. Balances are due within 30 days of the statement date. Delinquent balances over 60 days old may be referred to an outside collection agency. Retina Associates of Kentucky reserves the right to dismiss patients with delinquent accounts.

**Payment Plans:** If you are an established patient, and your doctor recommends medical care that you cannot afford at the time of service, Retina Associates of Kentucky may allow you to set up a payment plan to pay for the services. You may be asked for financial information to verify your financial need and determine a fair monthly payment.

**Patient Assistance Programs:**
We often enroll patients in grants and assistance programs to help pay for the cost of injectable drugs. These programs often have a copay amount similar to an insurance copay. You are responsible for paying this copay at check out on days you receive an injection. Also note these programs open and close at will. If the foundation runs out of funds, you are still responsible for any unpaid drug coinsurance.

**Account Credits and Refunds:**
If you have a credit on one date of service due to an overpayment but an unpaid balance on another date of service to where your total account balance is under $15.00, you will not receive a statement in the mail, however you are still responsible for the unpaid balance. By signing this form, you are giving us permission to use any encounter credits to pay other encounter balances. If you have a credit and no unpaid balances, you will be issued a refund.

**Medical Records and Form Requests:** You are entitled to one free copy of your medical record. Any subsequent copies will be charged at $1.00 per page. There will be a charge for completion of FMLA, Disability or other form requests.

**Appointment No Show and Cancellation Fees:**
You may be charged a fee for chronic appointment no shows or short notice appointment cancellations.

Payment for services may be paid by cash, personal check, Visa, MasterCard, Discover, American Express, or Care Credit. You will be responsible for any collection fees, interest, and other expenses necessary to collect on any account, including court costs should legal action be necessary to collect. A fee of $35 will be charge for any returned check from the bank for insufficient funds.

I have read and understand the aforementioned financial responsibilities and agree to abide by them.

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| Printed Name of Patient | RAK Patient Medical Record Number |
| Signature of Patient or Guardian | Date |