RESPONSIBLE PARTY INITIAL THE FOLLOWING, AS RECORD OF FINANCIAL DISCLOSURE:

_____1. I understand that it is my responsibility to know my insurance benefits and plan coverage. My insurance may or may not cover the services provided at **Retinal Consultants of Arizona (RCA)**. Please check with your insurance carrier, prior to your visit, to fully understand anticipated out of pocket costs.

_____2. I understand that RCA will collect ***Estimated fees***, at or prior to surgery and clinic visits, which include co-payments, deductibles, coinsurance, unpaid balances and non-covered services. Cash, checks, MasterCard, Visa, Discover, and Debit Cards are accepted. Payment is due upon receipt of statement for balances not covered by my health plan. If my insurance pays me directly for services billed by RCA it is my obligation to forward the payment to RCA.

_____3. I understand that RCA accepts both vision and medical plans. Vision plans cover routine eye exams and eyeglasses/contact lenses. All other billable services are usually sent to medical plans.

_____4. I understand that a refraction fee will be collected, following services, if I do not carry vision benefits and/or after surgery during the final post-operative visit if testing is necessary (only for patients receiving post op care at RCA).

_____5. I request that payment of authorized medical benefits be made on my behalf to all related entities involved or participating in my eye care associated with RCA. I authorize release of medical information necessary to my claim(s).

_____ 6. I understand that a $25 service fee will be added for any checks returned for any reason and I will be responsible for payment of this fee and the amount of the returned check. Non-sufficient fund checks must be redeemed with certified funds (cashier's check, money order or cash).

_____7. I understand the following No Show/Cancellation Policy:

- ***Clinic appointments*** canceled less than a 24 hour advance notice or failure to show up for an appointment will be charged a $25 fee for the first occurrence, $50 for two or more occurrences. If I arrive 30+ minutes late for an appointment, I may be rescheduled at the physician's discretion.
- ***Surgery appointments*** canceled less than a 48 hours advance notice or failure to show up for an appointment, without immediate rescheduling, will be charged a $100 fee.
- ***Oculoplastic Surgery appointments*** canceled less than a 17 day advance notice or failure to show up for an appointment, without immediately rescheduling, will be charged a $250 fee (functional appointment) or 15% of the charge estimate provided (cosmetic appointment).

_____ 8. I understand that my credit card information will be kept securely on file. It will automatically be charged for amounts not covered by insurance for services, outstanding balances, deductibles, copayments and arrangements established between myself and the RCA billing department.

_____ 9. I understand that there may be fees associated with medical records requests and completion of forms by a physician. I understand that I may be responsible for paying these fees.

_____10. I understand that if my account has a patient responsibility amount that is not paid within 90 days then my account will be placed with an outside collection agency. No additional appointments may be made for delinquent accounts until they are brought current unless the appointment is of an urgent nature.

_____11. RCA will charge a fee of $50 for the completion of forms/paperwork which is due at the time of the request. Forms received directly from you or your employer takes considerable time to complete. The turnaround for completion can take up to fifteen days.

STATEMENT OF FINANCIAL RESPONSIBILITY: I acknowledge that I am responsible for all charges for all services provided, including any amount not paid by my health care plan(s). This also applies if I am covered by Medicare, a health maintenance organization (HMO), or any other payer. I have read and understand the above Financial Policy and I agree to abide by its terms.

Printed Name of Patient: _____ID:_____

Signature of Patient/ Responsible Party: _____ Date: _____