RETINA INSTITUTE OF MICHIGAN

FINANCIAL POLICY

Thank you for choosing The Retina Institute of Michigan as your healthcare provider. We are committed to providing you with high quality care. Our office staff members will work very hard to make sure you have a positive experience with us. Due to the changes as a result of the Affordable Health Care Act, The Retina Institute of Michigan has determined it necessary to implement the following financial policy. Please make sure to read the following in its entirety and sign that you have read and understand this policy.

WE ACCEPT MASTERCARD, VISA, AMERICAN EXPRESS, DISCOVER, CASH AND CHECKS.

Insurance and Insurance Collection
Please understand that insurance reimbursement can be a long and difficult process for our office. Please bring all of your insurance cards to each and every appointment and notify the staff if there have been any changes in your policy.

Medicare and Medicare Advantage Plans
As a participating provider, we will bill your Medicare carrier. **If you have a Medicare Advantage plan, you must present us with the appropriate insurance card along with your traditional Medicare card.** You are responsible for your annual deductible and 20% coinsurance and we must collect it. We will be happy to bill your secondary payer as well. If a balance remains after we bill Medicare and your secondary insurance carrier, we will bill you for the balance, which is payable by you upon receipt of your statement.

Medicare Patients Residing in a Rehab or Skilled Nursing Facility
Patients temporarily or permanently residing in a rehab or skilled nursing facility often have restrictions on services approved for payment in physician offices. It is critical that you let our office staff know this information and have the facility information available even if the reason for the stay is unrelated to your eye condition. Prior authorization needs to be obtained for any services provided to you in our office while you are staying in one of these facilities. Lack of prior notification could result in the patient being responsible for the balance.

HMO Plans
All co-pays must be paid at each and every visit. There can be no exceptions due to contracting and uniform compliance rules. **You are responsible for getting proper referral information and authorizations in advance of your appointment. It is the patient's responsibility to verify with your insurance company that the physician is enrolled in your insurance plan.** You will be responsible for payment for services denied by your HMO for lack of referral and/or pre-authorization.

PPO Plans
We have agreed to accept the discounted rate from your plan, however all co-insurances and deductibles are your responsibility, and due at the time of each and every visit.

Co-payments, Co-insurance and Patient Deductibles
All co-payments, deductibles, share of costs and co-insurances are due at the time of service. Your insurance company deducts this from our payment automatically. The Retina Institute of Michigan reserves the right to charge a finance fee of 1% of your patient balance if not paid within 60 days past the date of the statement unless a payment arrangement has already been made with our billing office.

Financial Assistance for Injectable Medications
Due to the high cost of some ophthalmic injectable medications, we ask that you investigate your insurance to better understand your benefits and investigate insurance coverage when you have the option to switch plans. We also ask that you follow through with these available patient Assistance Programs to minimize your potential cost for these expensive medications. We will do our best to assist you with any part of this process and are committed to helping you determine your eligibility for these programs. Physician office staff can facilitate getting you the appropriate forms to complete for these assistance programs and it is your responsibility to follow up to ensure timely submission. **Ultimately, you are responsible for any costs not covered by your insurance or drug assistance program.**

No Insurance or Services not Covered by your insurance
Patients without any health insurance or patients who have some coverage but not for the services provided are expected to pay in full prior to or at the time of service. This includes all office visits, tests, injections, and surgical procedures.

Unpaid Balance Fees
The Retina institute of Michigan reserves the right to charge a fee of 1% for each statement sent to you for any patient-responsibility balance past due. This fee will not be assessed for the first statement sent.

About your information
We require you to bring your insurance card(s) with you to every office visit. It is your responsibility to keep us informed of any changes in your insurance coverage. **Insurance claims denied because you did not provide current and correct information will be due and payable by you.**

We require that you update your address, telephone and employer information with us whenever there is a change. We are not responsible for delinquent accounts due to lack of receipt of statements or other correspondence. Notices are assumed to be acceptable if they are returned to us as unclaimed, forwarding order expired, or otherwise undeliverable.

Form Completion and Record Copying
Additional fees may be charged for form completion, including disability forms, etc. Fees vary depending on the complexity of the forms. Fees for copies of medical records will be in accordance with the State of Michigan Medical Records Access Act.

Returned Check Fee
There is a $25 banking fee for all returned checks. If your check is returned from the bank, we will not accept a check as payment on your account. Future payments must be made with cash, money order, or credit card
I understand and agree that I am responsible for all charges pertaining to my medical care, regardless of my insurance status. I have read, understand and agree to the Financial Policy. I have completed the Patient Registration Form and the information is true and correct to the best of my knowledge. I will notify you of any changes.

Signed: _____ Date: _____

Patient Name (Printed) :_____