Visionary Retina CENTER

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DIPLOMATE, AMERICAN BOARD OF OPHTHALMOLOGY
DISEASES OF THE RETINA & VITREOUS

GENERAL OFFICE POLICIES

Please read the following information. By signing this document, you confirm and agree with the following:

1. If you are not feeling well: For the protection of our patients and staff, please reschedule if you are not feeling well or are contagious.

2. It is your responsibility to inform our office at the time of check-in if you have any changes to your name, phone numbers, insurance, emergency contact information, or your other healthcare providers. This will allow us to update your chart to have the correct information to provide when sending letters to your healthcare providers and insurance carriers, etc. Please notify us ahead of your visit if your insurance has changed from past visit.

3. Appointment Length: For a new patient, the visit may take 1-3 hours. Each return visit can take up to 2 hours. This time could be longer if a patient is added in as an emergency. We operate in the most efficient manner possible; however, please be aware that, although infrequent, emergencies can disrupt our schedule.

4. No Show/Cancellation Policy: When an appointment is scheduled, that time has been set aside for you. When missed, that time cannot be used to treat another patient. Therefore, we require you to give our office 24 hours' notice if you need to reschedule your appointment. If you miss an appointment without contacting our office with providing at least 24 hours' notice, that is considered a missed/no-show appointment. A $50.00 administration fee will then be charged to you; this fee cannot be billed to your insurance company and will be your direct responsibility.

5. ID/Insurance Cards: You are required to bring a photo ID and any applicable insurance card(s) that you may have to each appointment.

6. Food/Cell Phones: Beverages and cell phone use are not permitted beyond our waiting room. We do not permit the consumption of food in our office. Please turn off your cell phone before going to the exam room.

7. Copies of Patient Records: If medical records are requested, the charge is $20 for the first ten (10) pages and $1 per page thereafter. Copies of records will be faxed or electronically submitted directly at no charge to other healthcare providers. Fundus photos, fluorescein angiogram, and OCT image requests will be charged at the rate of $25 per date of service. Please note that a completed Release of Medical Records form is required before the office provides any imaging or medical records.

8. FMLA/STD Paperwork: If you need any Family Medical Leave Act/Short Term Disability forms completed for your employer, please allow 5 to 7 business days for our office to review and complete

these forms. We are unable to complete any forms on the same day. There is a $25 fee associated with the completion of such forms.

9. Financial Policies: We are dedicated to providing our patients with the best possible care and service while keeping the cost to you from rising at unreasonable rates. We ask for your help by understanding and cooperating with our Financial Policy.

It is important for you to understand that health insurance coverage is an agreement between you and your insurance company AND your doctor's bill for services provided is an agreement between you and your doctor.

YOUR Responsibility: *Visionary Retina Center* is a participating provider with most insurance companies. However, our list of accepted insurances is subject to change at any time, and not all plans under all companies are accepted. It is your responsibility to call your insurance company to verify that the doctor you are seeing is participating.
In order to avoid unexpected charges, please confirm that your particular health benefit plan is in-network for *Visionary Retina Center*. You should reach out to your carrier when you initiate care here to familiarize yourself with the limits of your policy and what will and will not be covered. We do our best to provide this information for our patients, but ultimately it is impossible for us to stay abreast of the requirements of the numerous insurance products on the market. It is your responsibility to understand the provisions, limits, and requirements of your individual benefit plan(s) and advise us accordingly.

Please be aware that, except as contractually agreed otherwise by *Visionary Retina Center*, you are ultimately responsible for insuring payment for all medical services provided. If a carrier denies payment for services because a plan requirement was not met, services were considered "non-covered," the plan benefits were exceeded, care is not considered medically necessary, or treatment is considered experimental, among other reasons, you will be held responsible.

If we do not participate with your insurance company, we will bill your insurance carrier as a courtesy to you; however, we will expect payment from you. If you do not have valid insurance information, or we cannot confirm coverage, we will consider you "self-pay" and ask for full payment.
All co-payments, co-insurances, deductibles, and payments for non-covered services are the patient's responsibility and will be collected by our staff at the time of service.

Referrals: If your insurance company requires a referral/authorization from the Primary Care Physician, be sure that you have obtained a valid referral/authorization prior to your appointment. If you do not have a valid referral/authorization, you may be asked to reschedule. You agree to be responsible for payment of your account regardless of referral status.

You understand that it is your responsibility to know and abide by the terms of your benefit coverage, including but not limited to properly securing referrals for specialized care before making appointments. You also understand that you are responsible for full payment of services provided if you fail to supply all required referral forms.

ALL INSURANCE PLANS, including but not limited to Medicare Replacement Plans, Managed Care, and Commercial Carrier Plans: Should the insurance benefit verification determine you only have Urgent and Emergent Care Coverage, and your services are not urgent/emergent, you will be responsible for paying the fee for all services at the time of service.

PAYMENT FOR SERVICES PERFORMED

- Our office accepts Visa, MasterCard, Discover, and American Express, as well as Cash, Debit Cards, and Personal Checks for payment of service. There will be a $35.00 fee for all returned checks.
- Any co-payments required by an insurance company must be paid at the time of service. This is an insurance requirement.
- You agree that in return for the services provided to you by *Visionary Retina Center*, you will pay your account at the time service is rendered or will make financial arrangements satisfactory to *Visionary Retina Center* for payment. Any balance not covered by insurance is due within 30 days of your visit. Non-paid accounts are referred to a collection agency ninety (90) days after the first charge. If an account is sent to a collection agency and/or an attorney for collection, you agree to pay collection expenses and reasonable attorney's fees that our office incurs through the process utilized to collect the outstanding delinquent balance. Any benefits of any type under any policy of insurance insuring you, or any other party liable to you, is hereby assigned to *Visionary Retina Center*. If copayments and/or deductibles are designated by your insurance company or health plan, you agree to pay them to *Visionary Retina Center*. However, it is understood that the undersigned and/or the patient are responsible for the payment of your bill.
- A $20 charge may be added to all amounts due over 30 days.

10. Credit Card On File Policy: We are committed to making the billing process as simple as possible. Many insurance plans require co-pays, co-insurance, and deductibles in amounts that are not always fully known to you, or to us, at the time of your visit. To make managing payments easier for both our patients and our staff, we require that you place a credit card on file at the time of check-in. A valid credit card, debit card, or HSA/FSA card will be accepted. Card on File Authorization: I authorize and request *Visionary Retina Center* to charge my card for balances due for services rendered that my insurance company identifies as my financial responsibility. I understand that a copy of my credit card will be kept on file. If my credit card declines, I will provide a new credit card number. This authorization will remain in effect until I cancel this authorization. To cancel, the account must be in good standing.

I fully understand and agree to abide by the policies as stated herein. *Visionary Retina Center* reserves the right to modify its policies from time to time.

_____	_____
SIGNATURE – Patient or Patient's Authorized Representative	DATE
_____	_____
PRINT NAME - Patient or Patient's Authorized Representative	Relationship to Patient
_____	_____
WITNESS – Name and Signature	DATE

COVID POLICY

At *Visionary Retina Center*, we take the utmost care in providing a safe environment for our patients and staff. As a newly constructed facility with an updated HVAC filtration system, we offer enhanced air cleanliness as recommended per CDC guidelines.

Appointments are spaced out strategically to minimize overcrowding of waiting rooms and patient-patient contact.

Exam rooms and equipment are disinfected after each patient encounter.

We follow CDC recommendations regarding masking at healthcare facilities. As many of our patients are immunocompromised and high-risk, we ask that you are especially considerate to your fellow patients.

Please contact our office if you have any questions regarding this information.

Thank you for your consideration and for trusting us with your care.