SOUTHEASTERN RETINA SPECIALISTS

FINANCIAL PRACTICES DISCLOSURE

Welcome to Southeastern Retina Specialists. Our practice participates in many medical insurance plans. If we are participating providers for you plan, we will file the claim on your behalf. If your plan does not cover services provided by our physicians, payment in full is expected at the time of your visit. We accept cash, checks, most major credit cards, and Care Credit. Please be sure to provide us with your most current insurance card(s) at each visit and advise us of any changes. Many insurance plans are no longer using the social security number as the patient ID, and have changed to using the Employee ID as the subscriber number. If you are not the primary cardholder please make sure you give us the correct subscriber (employee) ID number at the time of your visit.

All of the insurance plans we are contracted with require that we provide the patient's full name, date of birth, social security number, and complete home address. If you are uncomfortable providing us with this information, we will provide you with a bill so you can file your own claim with your insurance plan. If you choose to file the claim yourself, payment in full will be due at the time of service.

Copayments/Coinsurance/Deductibles: If your plan requires that you pay a copayment, deductible or coinsurance, you are required to pay at the time services are rendered.

Self-Pay Patients: Patients with no insurance are expected to pay at the time of service for all care rendered.

Authorizations/Referrals: Many insurance plans require a referral/authorization for office visits and/or procedures. You will need to obtain this referral/authorization from your primary care or referring physician prior to being seen in our office. If you are having surgery we will assist in getting pre-certification or prior approval for your procedure.

Non-Covered Services: On occasion, we may render a service that is not covered by your insurance plan. We make every effort to inform you of this in advance. Any non-covered services will become due and payable by you upon notice from your insurance carrier.

Out-of-Network Services: During the transitional period associated with starting a new practice, we will make every effort to work with your insurance company to obtain authorization for your care with the same in-network benefits that you currently have. In most cases, this is not a problem and your insurance carrier will allow us to treat you just as if we were an in-network provider. If there is an instance where this is not possible, we will make whatever adjustments necessary so that you are not charged anything more than if you had seen an in-network provider. Please know that we are making every effort to become participating with the primary payers in our region. Unfortunately, the process can sometimes be lengthy. We will keep you informed!

Affordable Care Plans/Healthcare Exchange: If you have an Affordable Care Plan, you are responsible for paying your healthcare insurance premiums in a timely manner. Failure to pay your insurance premiums will result in your benefits being terminated. If your insurance is cancelled for failure to pay your premium, you will be held liable for the amount of the bill for the services rendered by our physicians. This amount will be due in full upon notice.

I certify that the information given by me in applying for payment under my insurance contract is correct. I authorize any holder of my personal information, whether medical or otherwise, to release to any third party payers (including Medicare, Medicaid, and other parties) information needed to process claims for health care benefits. I request that payment of authorized health care benefits be paid and I assign the benefits payable for physician services to the physician or organization furnishing the services. I understand that I am financially responsible for charges not covered by the insurance company, and I hereby guarantee timely payment in full of any such charges.

By signing below, you are acknowledging that you have read and fully understand our Financial Policy.

X _____ _____

Patient Signature **Date Signed**

Relationship to patient (If signed by a personal representative of patient)**:** _____

Patient Name: _____ **DOB:** _____

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