Retina Consultants of Southern California

Assignment of Benefits/ Financial Policy

Financial Responsibility

We are committed to providing you with the highest level of service and quality care. Our office strives to help you receive the maximum allowable benefits from your medical insurance. However, any and all financial liability rests with the patient. Please be aware that all copays, deductibles, and coinsurance payments are due at the time of service, unless you have made prior arrangements with our billing office. We will file any necessary forms with your insurance carrier for payment. However, if we are not notified of changes to your insurance coverage before your visit, you will be responsible for all incurred fees. This includes changes to your HMO Managed Care Plan or Medical Group. Returned checks will incur a $35 fee, which will be added to your account.

If you have an outstanding balance and fail to make payment or payment arrangements, your account may be placed with an external collection agency. Any balance past due will automatically incur a 30% increase if forwarded to a collection agency. RCSC and the designated collection agency are authorized to contact you by any provided phone number(s), including text message, email, and other contact methods.

For services provided to minor/dependent patients, we will look to the accompanying adult, parent, or guardian for payment. If you are using insurance for a dependent enrolled under a subscriber other than yourself, please provide their name, address, phone number, date of birth, and social security number. We also ask that you inform the subscriber that their insurance has been used.

Assignment of benefits

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan to issue payment check(s) directly to Retina Consultants of Southern California services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information

I hereby authorize Retina Consultants of Southern California to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from Retina Consultants of Southern California on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date the services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

CONSENT TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

By signing this form, you are granting consent to Retina Consultants to use and disclose your protected health information for the purpose of treatment, payment and healthcare operations. Our *Notice of Privacy Practices* provides more detailed information about how we may use and disclose this protected health information. You have the legal right to review our *Notice of Privacy Practices* before you sign this consent, and we encourage you to read it in full.

Patient Name: _____

Patient/ Responsible Party Signature: _____

Date: _____