FINANCIAL POLICY AGREEMENT (FPA)

Change effective date January 24, 2018

Thank you for choosing Retina Institute of Virginia, PLLC as your healthcare provider. We are committed to providing you with high quality care. Our Medical and Business 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, Retina Institute of Virginia, PLLC 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, DISCOVER, DEBIT CARDS, CHECKS AND CASH.

Please initial and then sign the following:

_____ **1. Picture Identification**
Due to widespread insurance fraud and identity theft, picture identification is required when you register in our office.

_____ **2. Insurance & Insurance Collection**
Please bring all of your insurance cards to each and every appointment and notify the staff if there have been any changes to your policy. Please understand that insurance reimbursement can be a long and difficult process for our office. In fact, we have experience with insurers stalling, denying, and reducing payments.

_____ **3. 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% co-insurance which must be collected. 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 our statement.

_____ **4. 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.

_____ 5. 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 our 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.

_____ 6. Co-payments, Co-insurance and Patient Deductibles

All co-payments, deductibles, share of costs and coinsurances are **due at the time of service**. Your insurance company deducts this from our payment automatically. Bills unpaid for more than 120 days will be turned over to a third party and/or collection agency. Additional fees may be incurred in the collection of any outstanding balances and may also result in your dismissal from the practice.

_____ 7. 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 also 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 programs.**

_____ 8. No Insurance or Services not Covered by your Insurance

Patients without any health insurance or patients who have coverage but the services are not covered by your insurance are expected to pay **in full prior to or at the time-of-service**. This includes all office visits, tests, injections and surgical procedures. A minimum of $250 is expected at the initial visit. At visit check out the balance due is expected.

_____ 9. 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 in a timely manner 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.

_____ 10. Form Completion and Record Copying

From time to time, you may ask us to complete various forms (such as disability forms). There is a $25 service fee to complete these forms. Payment is due prior to us giving those completed forms to you. This charge is not covered by your insurance company and offsets the costs we incur to complete these forms. Please allow 7 to 14 business days. Medical records to be released to another provider are provided at no cost. We may charge up to $25 for the reproduction of your medical records based on guidelines from the Commonwealth of Virginia and the Federal Government. See attached fee schedule.

_____ 11. Returned Check Fee

There is a $30 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, debit card or credit card.

_____ 12. ***I understand that failure to maintain a current account with Retina Institute of Virginia may result in further non-emergent medical treatments not being provided and/or dismissal from the care of Retina Institute of Virginia***.

_____ 13. <u>AUTHORIZATION TO PAY BENEFITS:</u>

I authorize and direct said agency or insurance company to pay benefits, or insurance payments made on my behalf, directly to Retina Institute of Virginia, PLLC, for professional services rendered. I understand this in no way relieves me of my personal responsibility for paying my responsible portion when a statement is rendered. It is understood that the signing of this form does not prohibit customary monthly billings.

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 information forms and the information is true and correct to the best of my knowledge. I will notify you of any changes.

_____ _____

Signature of Patient or Responsible Party Date

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Printed Name of Patient

Virginia Guidelines for Providing a Copy of Medical Records
Search Fee: $10.00
Pages 1 – 50: $0.50 per page
Pages 51+: $0.25 per page