



FINANCIAL / CREDIT POLICY

In advance of your appointment, the physicians and staff of Retina-Vitreous Surgeons would like you to understand our financial policies. If you have questions regarding this document, please call our billing department at (315) 445-8179.

At Check-in: You must present your insurance card (s) for each visit.

Co-Payments: Co-payments are due and payable when you arrive. We accept cash, check, or VISA, MasterCard, Discover and American Express credit cards.

Referrals/Authorizations: It is your responsibility to ensure that we participate with your insurance carrier and whether or not you need a referral or authorization for the visit or procedure.

High Deductible Plans: When you arrive, you be expected to pay \$290.00 toward the visit and services for the day. You will receive a statement for any balance after we have submitted a claim to your insurance. If your payment results in a credit balance, we will promptly refund that amount to you.

Balance Due: Balances are due either when you arrive at your next appointment or upon receipt of your first statement, whichever comes first. Failure to pay your balance will place you at risk of being discharged from our practice and having your account forwarded to a collection agency. Additional fees may apply to accounts that are forwarded to a collection agency.

No Fault or Workers' Compensation: You are responsible for providing your No Fault or Workers' Compensation information at the time of your arrival. Failure to provide this information will place your account in self-pay status and you will be responsible for all charges.

Self-Pay Patients: If you are without insurance, please contact our billing department at (315) 445-8179 prior to your visit to arrange payment terms. You are required to pay \$290.00 at the time of your arrival for your first visit. If you are having surgery, we will give you an estimate of charges at the time of your visit. You will be asked to sign a self-pay contract and payment arrangement prior to your surgery.

No Show or Late Cancellations: Failure to show up for a scheduled appointment or cancelling less than 24 hours in advance of appointment may result in a fee of \$50.

I have read this document and understand and agree to all of the terms and conditions.

SIGNATURE OF PATIENT OR LEGAL GUARDIAN

DATE

PRINTED NAME

DATE OF BIRTH

Syracuse

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Liverpool, NY 13088
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Fax 315-445-2697

Watertown

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Watertown, NY 13601
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Binghamton

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Fax 315-445-2697

Ithaca

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New Hartford

8411 Seneca Turnpike, Suite 106,
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