RETINA-VITREOUS SURGEONS OF CENTRAL NEW YORK, P.C.

www.rvscny.com

FINANCIAL/CREDIT POLICY

The physicians and staff of Retina-Vitreous Surgeons of Central NY, P.C. are dedicated to the best possiblecare for you, and we want 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 insurancecarrier and whether you need a referral or authorization for the *visit* or procedure.

High Deductible Plans: When you arrive, you will be expected to pay $290.00 toward the *visit* and services for that 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 yourfirst 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. Additionalfees may apply to accounts that are forwarded to a collection agency.

Medicare Authorization for Assignment of Benefits and Information Release:

I request that payment of authorized Medicare benefits be made on my behalf to Retina-Vitreous Surgeons of Central NY, P.C. for any services rendered by a physician of the group. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information to determine these benefits payable for related services.

Private Insurance Authorization for Assignment of Benefits and Information Release:

I authorize payment of medical benefits to Retina-Vitreous Surgeons of Central NY, P.C. for any services rendered by a physician of the group. I understand that I am financially responsible for any amount not covered by my contract. I also authorize the release to my insurance company or their agent information concerning health care, advice, or treatment provided. This information will be used for the purpose of evaluating and administering claims of benefits.

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 -81 79 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 lessthan 24 hours in advance of appointment may result in a fee of $50.

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

SIGNATURE OF PATIENT OR LEGAL GUARDIAN _____ DATE _____

(PRINTED NAME IF LEGAL GUARDIAN) _____ (RELATIONSHIP TO PATIENT) _____

Syracuse
200 Greenfield Parkway, Liverpool, NY 13088
315-445-8166 • 800-654-0554
Fax 315-445-2697

Watertown
400 Washington Street, Watertown, NY 13601
315-445-8166 • 800-654-0554
Fax 315-445-2697

Binghamton
4104 Vestal Road, Suite 103, Vestal, NY 13850
315-445-8166 • 800-654-0554
Fax 315-445-2697

Ithaca
821 Cliff Street Suite 6, Ithaca, NY 14850
315-445-8166 • 800-654-0554
Fax 315-445-2697