The Retina Center Financial Policy

Thank you for choosing The Retina Center of Minnesota as your healthcare provider. We are committed to your treatment being a successful experience. Our goal at The Retina Center of Minnesota is to serve your medical needs as well as we possibly can. We also want to make the billing a non-issue right from the start. To achieve this, our Medical and Business Office staff members will work very hard to make sure your paperwork is filed accurately and promptly.

ABOUT YOUR INFORMATION: We require you to bring your insurance card 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 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 will be verifying this information, along with other demographic information (name, date of birth, emergency contact, and primary care provider), at every visit.

We are not responsible for delinquent accounts due to lack of receipt of statements or other correspondence.

WE ACCEPT AMERICAN EXPRESS, MASTERCARD, VISA, DISCOVER, DEBIT CARDS, CHECKS AND CASH.

INSURANCE AND INSURANCE COLLECTION:
Please understand that insurance reimbursement can be a long and difficult process for our office. In fact, insurers will routinely stall, deny, and reduce payments. Our billing staff has undergone extensive training to maximize your insurance reimbursement, while reducing the time by which they pay. Please **initial** next to your category of insurance listed below, as this will help us to speed up payment and eliminate any confusion in the future. Thank you.

______ **NON-CONTRACT INSURANCE PLANS:** We will bill your insurance company as a courtesy. Our office, as a convenience and a service to you, will absorb the costs incurred for billing. We require you to pay in full at the time of service. Your insurance company will send payment directly to you.

______ **SELF PAY AND PATIENTS WITH NO INSURANCE:** All services are your responsibility. Payment in full is preferred at the time of the visit. There is a 30% discount if paid in full on the visit date. The alternative is a down payment of $350 or 50% of the estimated cost of the visit, whichever is greater, at the time of the visit or when scheduling a surgery and an approved payment plan set up by a PSR in accordance with the practice's payment plan procedure.

Plans in which we are participating providers:

______ **VA/MILITARY INSURANCE PLANS:** You are responsible for getting proper referral information and authorizations in advance of your appointment. You will be responsible for payment for services denied by the VA/HealthNet for lack of referral and/or continued authorizations.

______ **HMO PLANS:** All co-pays must be satisfied 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. You will be responsible for payment for services denied by your HMO for lack of referral and/or pre-authorization.

______ **PPO, CHOICE, AND INDEMNITY PLANS:** We have agreed to accept the discounted rate from your plan, however all copays are due at the time of your visit, and co-insurance is your responsibility. We will estimate balances to the best of our ability.

______ **WORKER'S COMPENSATION:** This office has been thoroughly trained on how to get reimbursed by your employer; however, in the event there is a problem, you must provide us with the name of your human resources director and/or benefits manager. We may also require your authorization to file complaint letters to the Department of Labor and your administrator if necessary.

______ **MEDICARE:** As a participating provider, we will bill your Medicare carrier. You are responsible for your annual deductible and 20% co-insurance and we must collect it. 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.

______ **MEDICARE ADVANTAGE PLAN:** As a participating provider, we will bill your Medicare Advantage carrier. You are responsible for your annual deductible, copay or co-insurance and we must collect it. We will be happy to bill your secondary payer as well. If a balance remains after we bill your Medicare Advantage Carrier and your secondary insurance carrier we will bill you for the balance, which is payable by you upon receipt of our statement.

______ **MEDICAL ASSISTANCE/MNCARE PLAN:** As a participating provider, we will bill Medical Assistance. You are responsible for any copays, co-insurance, or deductibles that Medical Assistance states is your responsibility. You are also responsible for ensuring your coverage is active at the time of your visit.

ASSIGNMENT OF BENEFITS: You authorize all payments to be made to Retina Center, PA on your behalf for services rendered to you by the Retina Center of MN.

SECONDARY INSURERS: Having more than one insurer DOES NOT necessarily mean that your services are covered 100%. Secondary insurers will pay as a function of what your primary carrier pays. We will bill your secondary carrier. You are responsible for any balances after your insurance(s) has cleared.

CO-PAYMENTS, CO-INSURANCE AND PATIENT DEDUCTIBLES: All co-payments, deductibles, share of costs and coinsurances are due at the time of service. These items are your responsibility per your insurance carrier.

SERVICES NOT COVERED BY YOUR INSURANCE: Services not covered by your insurance are payable in full prior to or at the time-of-service. We will try to provide prior notification if you are going to receive a service that we know is not or may not be covered by your insurance.

CARE CREDIT: We accept/offer CARE CREDIT as a payment/financing option. Applications can be processed at the time of your appointment.

MISSED APPOINTMENTS: You will be charged a $35.00 missed appointment fee if you fail to arrive for your appointment.

MINOR PATIENTS: The adult accompanying a minor and the parents (or guardians) of the minor are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, Visa/MasterCard, or payment by cash or check at the time of service.

DIVORCE DECREES: This office is NOT a party to your divorce decree. Adult patients are responsible for their bill at the time of service. The responsibility for minors rests with the accompanying adult.

FORMS: There will be a charge for filling out forms based on your medical records. Fees vary depending upon the form.

REQUESTING A COPY OF RECORDS: We require that you complete an **Authorization to Release Medical Records** form as MN State law requires you to provide us with a written request. There is a fee charged for copying materials, the time it takes to copy the documents and retrieve your chart. The maximum fee is $1.34 per page and a maximum retrieval fee of $17.79 per MN State Statute 144.292. This will depend on how the release form is completed.

RETURNED CHECK FEE: There is a $35 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 or credit card.

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.

____ Date:____________________________

Signature of Patient or Responsible Party

____ Chart#___________________________

Relationship to Patient