Retina Associates of South Texas
Diseases and Surgery of the Retina and Vitreous

Financial Policy

Thank you for choosing Retina Associates of South Texas as your health care provider. The following information is provided for your benefit so that we may serve you better. We ask that all patients read and sign our financial policy as well as complete all other required forms prior to seeing the physician.

Payments: Patient is responsible for all the charges regardless of insurance coverage. All applicable fees, deductibles, co-insurance, co-pays and account balances must be paid at the time of your appointment. For your convenience, we accept Cash, Checks, Visa and MasterCard as a form of payment. Appointments may be rescheduled for non-payment of co-pays and/or previous balances.

Insurance: Your insurance policy is a contract between you, your employer (if applicable) and the insurance company. We are **NOT** a party to that contract. Our relationship is with **you.** We cannot become involved in disputes between you and your insurer regarding deductibles, co-pays, co-insurances, covered services, secondary insurance, referrals, and usual and customary charges**.**
Payment for services not covered by your insurance is your responsibility and is due at the time of service.

Cancellation of Appointment: If you need to cancel or re-schedule your appointment, please give us at least 24 hours notice for a regular appointment and at least 48 hours notice for a surgery appointment. Failure to notify us in due time will result in a **no-show or late cancellation fee of $25 for a regular appointment and $100 for a surgery appointment**. If you fail to notify us for three missed appointments we may decide to terminate your care with our office.

Referrals: If your insurance requires written authorization from your Primary Care Physician (PCP), we will request authorization ahead of time for established patients. This is done as a courtesy for you (patient), however, we can not guarantee authorization will be granted. **It is ultimately your responsibility to make sure that your visit is pre-approved or you will be responsible for payment in full.**

Change of Information: Please provide us with any changes/updates regarding your address, phone number(s) or insurance information as soon as possible. Failure to provide updated information may result in you receiving a statement for our services.

Returned Checks and Outstanding Balances: All returned checks are subject to **$35 returned check fee**. Balances older than 45 days may also incur a collection charge/fee.

Non-Compliance: We reserve the right to discontinue care with our office for non-compliance with any of the above policies.

By signing below, I, the Guarantor of Payment and Responsible Party, agree to the above policies and agree to the terms regarding payment and payment responsibilities. I authorize Retina Associates of South Texas and its staff to use and disclose my protected health information (PHI) for the purposes of examination and/or treatment, payment, billing and business operations, and to receive direct payment(s) from my insurance carrier for the rendered services.

Name: _____ Relationship to Patient: _____

Signature: _____ Date: _____