RETINA GROUP CHICAGO
Financial Policy

Consent to Treat
I voluntarily consent to such care and treatment as prescribed by the physician as is necessary in his/her medical judgment.

Patient/Responsible Party Initials: _____

Release of information and Assignment of Benefits
I authorize use of this form on all my insurance submissions and authorize release of information as needed to process claims to all my insurance carrier(s). I permit a copy of this authorization to be used in place of the original. I authorize the provider to act as my agent in helping me obtain payment from my insurance carrier(s). I understand the provider does not accept responsibility for collecting my insurance claims or for negotiating a settlement on disputed claims.

I assign all rights and claims for reimbursement of expenses allowable under my insurance plan and authorize payment directly to Retina Group Chicago. I understand that my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in Item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes the release of the information to the insurer or agency shown. I understand that I will receive a monthly statement for any balance due from me.

The Release of Information and Assignment of Benefits will remain in effect until revoked in writing by the patient.

Patient/Responsible Party Initials: _____

Patient Responsibility
I understand that Retina Group Chicago will submit claims to my insurance carrier(s) on my behalf, based on the information that I have provided to them. I acknowledge that I will be responsible for obtaining any referrals required and for payment of any co-payments, co-insurance, deductibles or charges for non-covered services or non-authorized services, in accordance with my insurance benefit plan(s).

I acknowledge that ***copayments*** are due at the **time of service** and that failure to pay my copayment at the time of service may result in an additional **service fee of $10**. I understand that if I have a high-deductible plan or if a non-covered service has been identified in advance that I may be asked to pay some or all of these amounts at the time of service.

Continued on Back Page

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I acknowledge that I will be responsible for all balances associated with non-payment by my insurance carrier(s) due to my lack of eligibility at time of service and/or not providing accurate information to allow for timely submission of my insurance claim.

I further acknowledge that if I ***do not have health insurance coverage*** or if my benefit plan does not cover medical services provided by Retina Group Chicago, I will be responsible for all charges incurred with Retina Group Chicago at the **time of service,** unless other arrangements are made.

Patient/Responsible Party Initials: _____

Service Fees

I acknowledge that there will be a $35 service charge for any check returned for non-sufficient funds. I further acknowledge that I will be responsible for any fees incurred to me if my account is forwarded to a collection agency for non-payment.

Patient/Responsible Party Initials: _____

Notice of Privacy Practices

I acknowledge that I have been offered a copy of the Notice of Privacy Practices.

Patient/Responsible Party Initials: _____

Please list anyone with whom we can share your information:

Name:_____ Relation: _____

Name: _____ Relation: _____

Name: _____ Relation: _____

My signature below acknowledges that I accept all of the above policies and procedures.

Patient Name (Please Print)	Date of Birth
Patient Signature	Date

If the patient was unable to sign this document, the responsible party must complete the information below.

Responsible Party Name (Please Print)	Relationship to Patient
Responsible Party Signature	Date

Revised: January 2, 2015