FINANCIAL / CREDIT POLICY

The physicians and staff of Retina-Vitreous Surgeons of Central NY, P.C. are deciated to the best possible care for you, and 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: It is the patients' responsibility to pay out of pocket for expenses before the insurance company will coverreamining costs. On the day of service, the patient will be respponsible for a fixed amount based on services rendered. 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.

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 arrive for your first visit to pay a fixed amount as designated by the practice. 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-paying 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