Arizona Retina Associates

Financial Policy

To help achieve our goal of providing the best medical care possible, we ask for your understanding and cooperation regarding the following payment/insurance policies.

Payments

Your insurance plan is a contract between you and your health insurance company. It is your responsibility to know your benefits and the limits of your coverage. We ask that payments, including copayments and applicable deductibles, be made at the time of service. For your convenience, we do accept cash, check, money orders, debit cards, and most major credit cards.

Self-pay Accounts

Self-pay accounts are for patients without insurance coverage, as well as patients covered by insurance plans in which the office does not participate. Self-pay patients will be required to pay for services performed on the date of service.

Workers' Compensation

It is your responsibility to provide our office staff with contact information regarding a workers' compensation claim at the time of service. If the claim is denied by your workers' compensation insurance carrier, payment for services then become your responsibility.

Overdue Balance Policy

When a balance is due, you will be sent three statements, one per month. If the balance has not been paid during this 90 day period, your account will be sent to a collections agency. In the event your account is turned over for collections, you will be held responsible for all collection costs and you may be discharged from the practice.

I hereby authorize Arizona Retina Associates to apply for reimbursement benefits on my behalf for services rendered to me. I understand that payment from my insurance carrier will be made directly to Arizona Retina Associates. I further authorize the release of any information necessary to process any claim with my insurance carrier. I understand that I am financially responsible for all charges not covered by my health insurance. I further understand that I will be responsible to pay for any service denied by my insurance company.

I have read and understand the payment policy and agree to abide by its guidelines

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Patient/Guardian Signature Date