Financial Policy, Assignment of Benefits, and Payment Policies

ASSIGNMENT OF BENEFITS:

I hereby assign all medical and/or surgical benefits, to which I am entitled, including Medicare, private insurance and any other health plans to Northwest Arkansas Retina Associates, P.A. (NWA-RA). This assignment is for services rendered to me by NWA-RA. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure this payment.

FINANCIAL POLICY:

PAYMENT: Payment is expected at the time of service. If your deductible has not been met, or a portion of the total charges is your responsibility, we expect payment when services are rendered. **Some procedures performed in our office may be subject to a deductible and/or co-insurance in addition to your co-pay.** Please provide the most current insurance information, your most current billing address, all available telephone numbers and any other important contact information. If your address or contact information changes, please provide the updated information, as soon as possible. If you fail to provide accurate insurance information, your insurance company may deny the claim. IF the claim is denied, you will be financially responsible for the entire amount. **It is your responsibility to know and understand the level of service covered by your insurance company.**

Even though insurance will be filed, YOU ARE RESPONSIBLE for any un-met deductibles and or co-insurance.

We will send a statement to the billing address provided indicating any balance you may owe after your insurance has processed the claim. If you have any questions regarding the balance, please contact our office within ten (10) business days after receipt of the initial statement. Payment is expected, **in full**, within 30 days of the receipt of your statement. You may contact our patient account representative at 479-419-9393.

A fee may be assessed for any insufficient funds checks that are returned by the bank.

ADMINISTRATIVE FEES: NWA-RA may assess an administrative fee up to $25.00 for requests from the patient for medical records and/or for our office to complete return-to-work, disability insurance or other administrative forms. A cancellation/reschedule fee may also be assessed for surgeries and/or procedures.

SELF-PAY (PRIVATE PAY): We offer a discount to patients who have no insurance. Patients who pay with cash or check will receive a 20% discount off of the billed charges. Patients who pay with Visa/MC/Disc will receive a discount of %15 off of the billed charges. We also offer Care Credit. Patients who choose to use Care Credit will receive a 5% discount off of the billed charges.

IN NETWORK INSURANCE: All in network insurance co-payment, co-insurance and/or deductibles are due at the time of service. We will ESTIMATE the amount you owe based on the information we receive from your insurance company. If your insurance plan requires a referral, please provide this at your initial visit. If your insurance company requires a referral and you fail to obtain one, your insurance company may deem your visit as "out of network" or "not covered" and you will be responsible for the total charges due. By signing below, you (the patient) acknowledge that it is the patient's responsibility to be aware of what services are covered and agree to pay for any service deemed to be non-covered or not authorized by the plan. **We do not file Workers' Compensation Claims.**

MEDICARE: Our physician is a participating provider with the Medicare program and accepts, as payment, the Medicare allowable. The patient is responsible for all deductible, co-insurance or co-payment amounts when applicable. If you have supplemental insurance to cover the portion of the charges that Medicare does not pay, please provide us with a copy of your insurance card and any forms your insurance company may require. Medicare and/or secondary carriers do not cover some procedures. In this rare instance, you may be asked to sign a waiver form, which states that you understand you will be financially responsible for these charges.

SECONDARY INSURANCE: If you have secondary insurance coverage, please provide the information to our office when you check in for your appointment. **As a courtesy**, we will file your secondary insurance. If we do not receive payment or are unable to reconcile the claim with the secondary insurance company, for any reason, you will be responsible for the balance due on the account.

Patient Name: ________________________________ **DOB:** ___________________

Patient Signature: ______________________________ **Date:** ___________________