MIDWEST RETINA CONSULTANTS, S.C.

DANIEL C. ALTER, M.D., Ph.D.
ENRIQUE GARCIA-VALENZUELA, M.D., Ph.D.
BRYAN M. KIM, M.D.
ANAND D. GOPAL, M.D.
REHAN M. HUSSAIN, M.D.

RETINA, MACULA AND VITREOUS
DISEASES AND SURGERY
FLUORESCEIN ANGIOGRAPHY

Financial Responsibility Agreement

Thank you for choosing Midwest Retina Consultants, S.C. We are committed to providing you with the highest quality retinal care. Please read and sign the following financial policy.

INSURANCE BILLING

• We will submit claims to your insurance company as a courtesy.

• You must provide accurate and up-to-date insurance information.

• Any claim denied due to incomplete or inaccurate information will become your responsibility.

CO-PAYS, DEDUCTIBLES, AND CO-INSURANCE

• Co-pays are due at the time of service.

• You are responsible for all deductibles, co-insurance, and non-covered services.

• If your insurance plan requires a referral, it is your responsibility to provide it.

NON-COVERED SERVICES

Certain services may not be covered by insurance, including but not limited to:

• Diagnostic imaging not deemed medically necessary by your insurer

PAYMENT TERMS

• Payment is due upon receipt of your statement.

• A $50 fee may be charged for returned checks.

• Accounts outstanding for more than 90 days may be sent to collections.

SELF-PAY PATIENTS

• Payment is due in full on the date of service unless other arrangements have been made.

AGREEMENT

I have read and understand the Financial Responsibility Agreement. I agree to be financially responsible for

all charges not covered by my insurance plan.

Patient Name: _____

Signature: _____ Date: _____

If signing for a minor or patient unable to sign:

Printed Name of Representative: _____

Relationship: _____

Witness: _____ Date: _____