The Retina Center of Western Colorado

STICK PATIENT LABEL

NAME:_____BIRTHDATE:_____

MAILING ADDRESS:_____
ADDRESS CITY STATE ZIP

DO YOU LIVE IN ASSISTED LIVING OR NURSING HOME: **YES NO** ARE YOU ENROLLED IN HOSPICE **YES NO**

PRIMARY PHONE: _____ ALTERNATE PHONE: _____

Please circle your preferred phone number above. Can we leave a detailed message **YES NO**

SSN: _____ GENDER: M F EMAIL: _____

RACE: _____ ETHNICITY: _____ LANGUAGE: _____

OCCUPATION (PREVIOUS IF RETIRED) _____Full or part time RETIRED?: **YES NO**

EMPLOYER: _____ PHARMACY: _____

MARITAL STATUS: **S M W D** SPOUSE/PARTNER: _____

EMERGENCY CONTACT: _____ RELATIONSHIP: _____PHONE: _____

EYE DOCTOR: _____ ADDRESS: _____

PRIMARY CARE PHYSICIAN _____ ADDRESS: _____

I understand that my eyes will be dilated at every appointment at The Retina Center. It is my responsibility to have a driver if I do not feel safe driving with dilated eyes. _____(initial)

I hereby authorize the release of medical information to my insurance carrier if it is required in the course of treatment. I understand I am financially responsible for all charges incurred for services rendered. I authorize all medical benefits to be paid directly to The Retina Center.

Signed:_____ **Date:**_____ 202201

Office use: MC + MA HMO OTHER MCD NONE WC/AUTO (DATE OF INJURY:_____)

PP_____ CP _____

The Retina Center of Western Colorado

William J. Waterhouse, MD Jonathan D. Harder, DO C. Kiersten Pollard, MD

FINANCIAL POLICY AND FEE AGREEMENT

NO INSURANCE/SELF PAY

Payment in full is due when the services are rendered. Charges will be discounted if payment is paid in full at the time of service. If payment in full is a hardship, payments can be made on a monthly basis. If no payment is received from the patient over a three-month period of time, the patient's account may be sent to a collection agency and/or patient will be dismissed from this practice.

IN NETWORK INSURANCE PLANS:

The physicians at The Retina Center are participating providers for Medicare, Rocky Mountain Health Plans, Medicaid, the VA and CIGNA. The Retina Center is subject to contract agreements with these companies regarding services we provide and policy limits. The Retina Center will bill these insurances in accordance with the contract agreement between the insurance company and The Retina Center. Your policy is a contract between you and your insurance company. If you have questions about coverage, please call your insurance company. Your deductibles and copays are due at the time of service. If precertification/preauthorization is required by your insurance company, it is your responsibility to inform The Retina Center before your appointment.

MEDICARE/MEDICAID

The Retina Center is a participating provider with Medicare and Medicaid. We will bill these insurances for charges for services by our physicians. Payment of deductible and copay is the patient's responsibility.

MEDICARE SUPPLEMENTAL INSURANCE:

The Retina Center will bill the secondary insurance one time as a courtesy to the patient. If no payment is received within 45 days of billing, the outstanding balance will be the patient's responsibility.

ALL OTHER INSURANCES:

The Retina Center does not participate in any other insurance plans. As a courtesy to the patient, we will bill your insurance company. However, your insurance policy is a contract between you and your insurance company. Therefore, we cannot become involved in disputes between you and your insurance company other than providing factual information as requested. You, the patient, are responsible for the timely payment of your account in full. If payment has not been received from your insurance company within 45 days, you will be billed for your account balance.

Deductibles and copays are due at the time of service.

If you think your insurance policy might not cover your charges at The Retina Center, you may pay in full at the time of service at a discounted rate. The Retina Center will bill your insurance company. If any payment is received from your insurance company, the difference will be returned to you.

We strongly suggest that you call your insurance company before your appointment to make sure a referral is not needed or to see if your insurance will cover your charges at The Retina Center. **It is the patient's responsibility to notify the Front Desk staff if a referral is necessary before your visit to The Retina Center.** Unfortunately, if approval is required for your appointment and this has not been done before your appointment, your appointment may have to be rescheduled.

PAYMENTS DUE FROM PATIENTS:

For all patients, if there is a balance due and no payment has been received over three billing periods, the account may be turned over to a collection agency and/or the patient may be dismissed.

It is the patient's responsibility to make sure The Retina Center has up-to-date, correct insurance information. If incorrect or incomplete information is given, the patient may be responsible for all charges. _____

By signing this form, I acknowledge that I have read or have had this form read and/or explained to me, and that I fully understand and agree with its contents.

Signed: _____ Date: _____20200701