**NORTHERN ILLINOIS RETINA**

**Financial Policy Agreement (FPA)**

Thank you for choosing Northern Illinois Retina to treat your retinal condition. We are committed to providing you excellent patient care. Below we have provided an explanation of our Financial Policy Agreement (FPA). Patients must complete the FPA and the Patient Information Form (PIF) prior to receiving any medical care from us.

**Please initial and then sign the following**:

_____ 1. Each patient is responsible for his or her own bill. Payment of all insurance co-payments, co-insurances and deductibles are to be paid in full at each visit and prior to any surgery. Your insurance policy is a contract between you and your insurance company. We accept cash, checks and major credit cards.

_____ 2. As a courtesy, Northern Illinois Retina will file claims to your insurance carrier(s). To accomplish this, you must provide all insurance policy information to our office. If the insurance company(s) that you designate is incorrect, you will be responsible for payment of the visit. Your bill is your responsibility, whether or not your insurance company pays.

_____ 3. "Self-pay" patients (and patients with limited health insurance or very high deductibles) are required to pay 100% of services rendered at each visit. A minimum of $250 is expected on the initial visit. For extended treatments, payment arrangements are available and can be made with the Billing staff prior to any medical evaluation, procedure or treatment.

_____ 4. Bills unpaid for more than 60 days will be turned over to a third party and/or collection agency. Additional fees will be incurred in the collection of any outstanding balances and may also result in your dismissal from the practice.

_____ 5. As a specialty group, some insurance companies require that an authorization or referral be obtained prior to your visit. **It is your responsibility to know if your insurance requires this and to obtain the referral/authorization.** If this is not done by the day of your appointment, you will be asked to reschedule or to pay for the FULL amount of the visit. If a claim is rejected because a valid authorization or referral was not in place, the full cost of the visit will be your responsibility.

_____ 6. A $35.00 fee will be charged on all returned checks.

_____ 7. From time to time, you may ask us to complete various forms (such as disability forms). There is a $25 service fee to complete these forms. Payment is due prior to us giving those completed forms to you. This charge is not covered by your insurance company and offsets the costs and time we incur to complete these forms. Please allow 7 to 14 business days.

_____ 8. We may charge up to $20 plus a per page fee for the reproduction of your medical records based on guidelines from the State of Illinois and the Federal Government.

_____ 9. ***I understand that failure to maintain a current account with Northern Illinois Retina may result in further non-emergent medical treatment not being provided and/or dismissal from the care of Northern Illinois Retina.***

_____ 10. AUTHORIZATION TO PAY BENEFITS: I authorize and direct said agency or insurance company to pay benefits, or insurance payment made on my behalf, directly to Northern Illinois Retina for professional services rendered. I understand this in no way relieves me of my personal responsibility for paying my responsible portion when a statement is rendered. It is understood that the signing of this form does not prohibit customary monthly billings.

By signing below, I acknowledge receipt of this FPA.

X_____ X _____ Date _____

Signature of patient or responsible party  Northern Illinois Retina representative