Retina Care Center, P.A.
Privacy Practices and Financial Agreement

_____ _____

Name *(print)* Date

NOTICE OF PRIVACY PRACTICES: The complete document that states Retina Care Center's Privacy Practices is available for you to read in full. It explains our commitment to maintaining the privacy of your private health care information. If you would like a copy we will provide it to you.

Please list persons to whom we can release your medical information:

_____ _____

DISCLOSURE OF PROTECTED HEALTH INFORMATION:

I hereby assign or transfer payment benefits made to me or on my behalf to Retina Care Center, P.C. for any services furnished to me by this physician/supplier. I further agree that I am responsible for payment of charges incurred by me that are outside of the scope of my insurance coverage or for which my insurance company has paid me.

I hereby authorize Retina Care Center, P.C. to release information acquired during the course of my examination or treatment to my referring physician or an appropriate insurance carrier. If a Medicare patient, I further authorize release to the Centers for Medicare & Medicaid Services and its agents any information needed to determine benefits payable for related services.

FINANCIAL AGREEMENT:

I agree that in return for the services provided to the patient by Retina Care Center P.A., I will pay my account at the time service is rendered or will make financial arrangements satisfactory to Retina Care Center for payment. If an account is sent to an attorney or a collection agency, I agree to pay collection expenses of up to $50 or 20%, of the total balance, whichever is greater, upon placement with an attorney or collection agency because of an unpaid balance on my account. I understand and agree that if my account is delinquent, any benefits of any type under any policy of insurance insuring the patient, or any other party liable to the patient, is hereby assigned to Retina Care Center. If copayments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Retina Care Center.

RETURNED CHECK FEE: I also understand that if one of my checks are returned to Retina Care Center for "insufficient funds" I will have to pay a returned check fee of $35 which will be added to my bill. However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.

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Signature of Authorized Party Date