Retina Northwest Payment Policy

Thank you for choosing Retina Northwest for your medical care. We are committed to providing you with quality, personal health care and appreciate your commitment to adhere to our payment policy agreement.

Patients are expected to provide identification and a current insurance card(s) at time of service. We bill insurance in accordance with all federal, state, and other contractual requirements. Please keep in mind that payment remains your responsibility. Even though you may have an insurance claim pending, you may receive a monthly statement for the outstanding balance of your account. Your insurance company will determine what amount, if any, you owe to Retina Northwest.

Self Pay Patients: A $400 deposit is required at the beginning of your initial visit. A $250 deposit is required at the beginning of any subsequent visits. You may have a balance left over after the deposit. If you are receiving an injection, the payment of the drug is required at the beginning of each visit in addition to the $250.00

No Show Appointments: Failure to provide advanced notice to cancel your appointment may result in a "no show" fee of $75.00. Notice of cancellation must be done 1 full business day prior to the appointment.

All accounts are due and payable within 30 days unless special arrangements are made with our Business Office.

For your convenience, we accept cash, money orders, checks, Visa, MasterCard, American Express, and Discover.

Attestation Statement:

I have read, understand, and agree to the above Retina Northwest Payment Policy. I understand that charges not covered by my insurance company, as well as applicable copayments, coinsurance, and deductibles are my responsibility. I understand that delinquent accounts may be assigned to a collection service.

I authorize that my insurance benefits be paid directly to Retina Northwest.

I authorize Retina Northwest to release pertinent medical information to my insurance company when requested, or to facilitate payment of a claim in compliance with HIPAA regulations.

PRINTED NAME

X

PATIENT SIGNATURE DATE