PACIFIC RETINA CARE®

Financial Agreement / Receipt of HIPAA Privacy Notice / Consent for Treatment 10/2012

We find that open communication with our patients regarding our financial policy assists us in providing the best possible service to you. Please take the time to read these policies concerning medical insurance benefits. If you have questions, please feel free to ask.

Medical insurance is intended to only be an aid and rarely covers 100% of the total cost of your medical care. Every plan has its own provisions, which we must abide by. Certain costs will be passed along to the patient, such as deductibles, co-payments and co-insurance amounts. As a patient, you have certain responsibilities: (1) to pay amounts not covered by your insurance carrier (2) to be knowledgeable about your plan's covered and non-covered services (3) to notify the Practice if there are any changes in your coverage. We will do our best to work within your plan to help you receive maximum benefits. Please be advised that responsibility for full payment is solely yours, whether or not you have insurance. If it becomes necessary to send your account to a collection agency or attorney, you will be responsible for all costs, interest, and attorney fees. There is a $25 fee for all checks returned for insufficient funds. Pacific Retina Care℠ reserves the right for all future payments by the undersigned to be paid in cash or money order. For all patient balances over 30 days, there is a $5.00 statement processing fee, cumulative per month, on unpaid monies due to the Practice. Pacific Retina Care℠ reserves the right to charge a no-show/cancellation fee for any office related visits and procedures.

Managed Care Plans: We participate with a full range of insurance plans in order to offer flexibility to our patients. Our medical providers strictly follow the regulations and guidelines of these plans. On the date of service, we are contractually obligated to collect any appropriate co-payments, co-insurance and deductibles from you, the patient, as per our agreement with the carriers.

Medicare: We participate with Medicare, and closely follow their billing guidelines. You will be responsible for your $140 deductible, or any unmet portion thereof, at the time of service. We will also collect the 20% co-insurance portion of Medicare's approved charges for covered medical services upon being informed of them by Medicare. If you have supplemental coverage, we will automatically submit your co-insurance to that insurance company. Since your Medicare supplemental insurance will not cover certain specified medical services, it is your responsibility to pay the fees for these non-covered services when we inform you about them, and ask you to sign an Advance Beneficiary Notice as required by Medicare.

All Other Insurance: Due to the complexities of insurance billing, it is necessary for us to collect the appropriate percentage payment or deductible due at the time of service as directed by your insurance company. We will then submit the claim to the insurance carrier, who will then reimburse Pacific Retina Care℠ for their portion of the covered services. If the carrier sends a reimbursement check to you, it is your responsibility to sign it over to Pacific Retina Care℠ immediately. Failure to do so will lead to sending your account to a collection agency or attorney.

Secondary Insurance: Patients who are covered by more than one medical insurance carrier should notify the Practice at the time of registration. It is your responsibility to know the limitations of your supplemental/secondary policy. If you have two insurance policies, the co-payment of the primary insurance is collected at the time of service.

Divorce Decrees: The Practice is NOT a party to your divorce decree. Adult patients are responsible for their bill at the time of service. The responsibility of minors rests with the accompanying adult. When presenting insurance cards for a dependent enrolled under a subscriber other than you, please be prepared to supply their name, address, phone number, date of birth and social security number. We request that you inform the subscriber that their insurance has been used.

Minor Patients: The adult accompanying a minor and the parents (or guardians) of the minor are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, credit card, or payment by cash or check at the time of service has been verified.

Services Not Covered by Insurance/Uninsured Patients: Services not covered by your insurance are payable in full prior to the time of service. We will try to provide prior notification if you are going to receive a service that we know is not or may not be covered by your insurance.

About Your Information: We require you to bring your photo ID and insurance card(s) with you to every office visit. It is your responsibility to inform the Practice of any changes in your insurance coverage, address and phone number(s). Insurance claims denied because you failed to provide current and correct information will be due and payable in full by you. We are not responsible for delinquent accounts due to lack of receipt of statements or other correspondence. Notices are assumed to be acceptable if they are returned to us as unclaimed, forwarding order expired, or otherwise undeliverable.

CONSENT FOR THE RELEASE OF MEDICAL INFORMATION/HIPAA PRIVACY POLICY: As the provider of healthcare services, we are hereby authorized to release any medical information required in treating you, for payment for services rendered to you or for other healthcare operations of Pacific Retina Care℠. Before we release information to parties other than for treatment, payment of your account or for healthcare operations, we will require a specific authorization from you. By signing below, you acknowledge that you have received Pacific Retina Care℠'s HIPAA Privacy Notice by verbal request. You have a right to restrict uses and disclosures of your health information as it pertains to treatment, payment and healthcare operations. If your restrictions are accepted, these restrictions will be binding. You also understand that Pacific Retina Care℠ is not required to agree to your requested restrictions. By signing below, you do not request any restrictions for uses and disclosures of your health information for treatment, payment or healthcare operations at this time. You understand that you have a right to revoke this consent at any time in writing, but if you do, your revocation will not have an effect of any actions we have already taken in reliance of this consent.

CONSENT FOR MEDICAL TREATMENT: I, the undersigned, am knowingly requesting medical services from Pacific Retina Care℠. I am requesting these services willingly and voluntarily. I execute the same as my free and voluntary act for the purpose of receiving the healthcare services. By my signature below, I warrant that I am eighteen (18) years of age or older, of sound mind, and not constrained nor under any undue influence. I understand that my physician will be responsible for providing me with an explanation of current information regarding my diagnosis, treatment and prognosis and will require my consent on any procedures performed on me. My physician will ensure that I am adequately informed and that I understand the indications of any procedure performed by a Pacific Retina Care℠ physician. I understand that I have the right to refuse such care, except in an emergency.

PACIFIC RETINA CARE®

I authorize Pacific Retina Care℠ to disclose/request my health information including copies of records as necessary to/from:

1. *Any health insurance plan, company of billing service that provides insurance coverage for me for the purpose of payment of charges.*
2. *Consulting and treating physicians, diagnostic facilities, labs, radiology/imaging, outpatient facilities and hospitals and other health providers for the purpose of continuity of care.*
3. *Any insurance company that provides liability insurance coverage for Pacific Retina Care℠ to evaluate clinical performance.*
4. *Any workers' compensation, no fault or administrative proceeding for the purpose of evaluating my medical condition.*

All medical information with no exceptions, will be disclosed/requested as necessary to/from the above. I authorize faxing of information as necessary. This authorization shall cover the period of time from my first visit to my last visit and will end 2 years after the date of my last visit. I permit a copy of this authorization to be used in place of the original.

ACKNOWLEDGEMENT AS SIGNER ON THE ACCOUNT: Upon my signature below, I attest that I have read and understand all the provisions discussed herein. Any questions I have asked have been answered to my satisfaction and to the extent where I can place my signature on this document. I understand my rights and obligations as a patient of Pacific Retina Care℠. Should the patient be a legal minor as defined in the State of Hawaii Statute, I hereby attest as the signer below, that I am the lawful guardian of the minor.

All Patients Must Read and Sign the Following Before Treatment Can Commence

ASSIGNMENT AND AUTHORIZATION

I authorize that my insurance benefits be paid directly to Pacific Retina Care℠. I acknowledge that I am responsible for full payment of services rendered. I have read the above information carefully, and agree with all of the terms.

I also authorize the release of any information necessary or helpful in processing the claim for reimbursement for medical services. This authorization is valid for the release of medical information to all insurance carriers.

As the signer below, I attest that Pacific Retina Care℠ has the right to maintain my signature on file for the purposes of filing claims. Additionally, my signature below will act as authorization for today's and future treatments, unless I rescind such authorization in writing.

_____
Printed Name of Patient/Guarantor on the Account

_____
Relationship if Other than Parent

_____ _____
Signature of Patient/Guarantor on the Account Date