FINANCIAL / CREDIT POLICY

The physician and staff of Highland Retina Associates, LLC are dedicated to the best possible care for you, and we want you to understand our financial policies. If you have questions regarding this document, please call our billing department at (812) 281-2608.

At Check-in: You must present your insurance card (s) for each visit.

Co-Payments: Co-payments are due and payable when you arrive. We accept cash, check, or VISA, MasterCard, Discover and American Express credit cards.

Referrals/Authorizations: Although we strive to verify all insurances prior to any appointment; It is your responsibility to ensure that we participate with your insurance carrier and whether or not you need a referral or authorization for the visit or procedure.

High Deductible Plans: When you arrive, you will be expected to pay any coinsurance, deductible and/or copay toward the visit and services for that day. If you need financial assistance, this needs to be discussed with the office prior to being seen. You will receive a statement for any remaining balance after we have submitted a claim to your insurance. If your payment results in a credit balance, we will refund that amount to you.

Balance Due: Balances are due either when you arrive at your next appointment or upon receipt of your first statement, whichever comes first. Failure to pay your balance will place you at risk of being discharged from our practice and having your account forwarded to a collection agency. Additional fees may apply to accounts that are forwarded to a collection agency.

No Fault or Workers' Compensation: You are responsible for providing your No Fault or Workers' Compensation information at the time of your arrival. Failure to provide this information will place your account in self-pay status and you will be responsible for all charges.

Self-Pay Patients: If you are without insurance, please contact our billing department at (812) 281-2608 prior to your visit to arrange payment terms. If you are having surgery, we will give you an estimate of the charges at the time of your visit. You will be asked to sign a self-pay contract and payment arrangement prior to your surgery.

Thank you for respecting this financial policy.

I have read this document and understand and agree to all the terms and conditions.

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SIGNATURE OF PATIENT OR LEGAL GUARDIAN DATE

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(PRINTED NAME IF LEGAL GUARDIAN) (RELATIONSHIP TO PATIENT)