FRONT RANGE
RETINA

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ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

Our *Notice of Privacy Practices* provides information about how we may use and disclose medical information about you. As provided in our notice, the terms of our notice may change. If we change our notice, you may request a revised copy. By signing this form, I acknowledge that I have had an opportunity to review a copy of the *Notice of Privacy Practices*, which is available online as well as in our office.

CARD ON FILE AUTHORIZATION

I authorize and request Front Range Retina, P.C. to charge my credit card for balances due for services rendered that my insurance company identifies as my financial responsibility. Health savings, flex spending, and debit cards may not be accepted. I understand that my card will not be charged until 30 days after a statement has been sent to my mailing address, during which I will have the opportunity to pay via cash, check, mail, or credit card. I understand that the credit card number, three or four-digit code, and billing zip code will be kept on file. If my credit card is declined, I will provide a new credit card number. If I refuse to leave a credit card on file, I understand that I may be required to leave a $300 deposit which will be applied to any outstanding balance following insurance processing of the medical claim for the services/treatments to be rendered. This authorization will remain in effect until I cancel this authorization. To cancel this authorization, the account must be in good standing.

LATE CANCELLATION AND NO-SHOW POLICY

When you schedule an appointment with Front Range Retina, we will dedicate enough time and resources to provide you with the highest quality care. Should you need to cancel or reschedule your appointment, please do so no later than 24 hours before your scheduled appointment to allow us time to schedule other patients that are needing an appointment. Any patient who fails to show or cancels/reschedules an appointment within 24 hours of their appointment will be considered a late-cancellation or a no-show, respectively, and may be charged a $25 late cancellation / no-show fee, which will be due prior to re-scheduling future appointments. After the third late cancellation / no-show, the patient may be dismissed from the practice.

PATIENT FINANCIAL RESPONSIBILITY

Recognizing the need for patients to understand what is expected regarding payment of medical services, we have established our financial policy regarding your patient financial responsibility, which is described below. It is our goal to remain sensitive to our patients' needs while providing quality medical care, and we encourage you to contact our office if a problem should arise regarding your account.

1. All co-pays required by your insurance company must be paid at the time services are rendered. We accept cash, check, and credit card.
2. It is your responsibility to be aware of the contract benefits of your insurance carrier or any copayment, co-insurance or deductible obligation. If your Insurance requires referrals for full benefits to be paid, it is your responsibility to verify that the referrals are in place prior to your visit.
3. We will file insurance claims for medical services rendered. We cannot file claims correctly without accurate information from you. Proof of insurance must be presented at each visit. If your insurance is inactive on the day services are rendered, you will be charged as a self-pay patient.
4. If you do not have insurance, payment in full is expected at the time of service.
5. You will receive a statement from our office following your insurance company's processing of the medical insurance claim. If you are dissatisfied with their payment, please contact your insurance carrier. Payment of the patient's portion of the balance is due upon receipt of the statement.
6. We are participating providers with Medicare, and therefore must accept Medicare's allowed charge for the services rendered. Medicare will pay 80% of the approved amount. The patient is responsible for the remaining 20%, plus any out-of-pocket deductible. We will write off the difference between what we charge and what Medicare approves. Please remember that although we accept assignment for Medicare, the patient is responsible, by law, for any portion of the approved amount not paid by Medicare or a secondary insurance company.
7. Responsibility for payment for services rendered to the child/children of divorced or separated parents rests with the parent who seeks treatment.
8. I authorize Front Range Retina, P.C. to release any information concerning my care for the purpose of claims to federal, state, city, or town government agencies, third party payers of all categories, doctors, and hospitals. I authorize payment directly to Front Range Retina, the insurance benefits including Medicare herein specified and otherwise payable to me.