GREATER POTOMAC RETINA

CHET B. PATEL, M.D.

7101 GUILFORD DRIVE, SUITE 201
FREDERICK, MARYLAND 21704
PHONE 301.662.2775
FAX 301.662.2776

20 EXPEDITION TRAIL
GETTYSBURG, PENNSYLVANIA 17325
PHONE 717.334.9006
FAX 717.334.9007

Financial Policy, Patient Bill of Rights and Responsibilities

Thank you for choosing Greater Potomac Retina. We are committed to providing excellent healthcare services to you, our patient. It is important that you have an understanding of our financial policy. All patients must read and sign this form prior to receiving services. It is your responsibility to provide us with your most current insurance information.

1. If you fail to provide accurate insurance information in a timely manner, your insurance company may deny the claim. If the claim is denied, you will be financially responsible for services rendered.
2. We must emphasize that, as medical providers, our relationship is with you, the patient, and not your insurance company. Your insurance is a contract between you, your insurance company, and possibly your employer. It is your responsibility to know and understand the level of coverage by your insurance company. **If your plan requires a referral, you must obtain it prior to your visit.**
3. We may accept assignment after verification of your coverage. Please be aware that some or perhaps all of the services may not be covered in full by your insurance company. You are financially responsible for services not covered by your insurance company.
4. Before receiving services, you must verify that we are participating providers for your insurance company. In the event we are not participating providers, we will file the initial claim as a courtesy. Payment, however, is due in full at the time of service.
5. We charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.
6. **Co-payments, coinsurance and/or deductibles are due at the time of service.** We will estimate the amount you owe based on information we receive from your insurance company. You are responsible for paying the full amount determined by your insurance company once they have paid your claim, regardless of our estimation. **It is your responsibility to provide us with your most current billing information.**
7. You must provide your most current billing address, all available telephone numbers and any other important contact information and if any of this changes, **it is your responsibility to contact us with the updated information.**
8. We will send a statement (to the billing address you provide) notifying you of any balances you may owe. If you have any questions or dispute the validity of any balance, it is your responsibility to contact our billing office within thirty (30) days after receipt of the initial statement.
9. Payment in full is due upon receipt of your statement. Patient balances not paid in full within thirty (30) days of the statement issue date are deemed past due. Past due accounts may be subject to a late fee and may be referred to a professional collection agency and/or attorney for further collection activity. You will be responsible to pay all collection costs incurred; including attorney's and court cost if applicable.
10. If you are not able to pay the balance due in full, you must contact our billing office to discuss a payment schedule. If you fail to make payments as agreed upon, your account may be referred to a professional collection agency.
11. If your account is assigned to a professional collection agency, you will be notified by certified mail that you will no longer be able to receive services from any of the physicians Greater Potomac Retina. Failure to accept this certified (and/or pick it up at the post office) serves as notification of termination of services.
12. In the event you submit payment by check and the bank returns the check unpaid for any reason, we will add $30.00 to your original balance. In addition, we may seek additional legal remedies provided to us under Maryland law.
13. Failure to keep your balance current may require us to cancel or reschedule your appointment. Full payment is due at the time of service. We accept cash, checks, and credit cards. I have read and understand this financial policy.

Print Patient Name _____

Patient/Responsible Party Signature _____

Date: _____