PAYMENT/FINANCIAL POLICY

As a courtesy, Janigian Retina Associates, checks your insurance eligibility. This is not a guarantee of benefits or payment. The claim will process according to your health insurance plan.

It is the policy of Janigian Retina Associates that payment is due at the time of service. We require all patients to pay their deductible, copay and/or coinsurance payment at the beginning of each visit. The Assistant Office Manager is available, if you may have any questions.

If you are covered by health insurance with medical benefits, we will be happy to bill your insurance. Please provide your insurance information to the front office staff and we will verify your eligibility coverage as a courtesy. Accepting your insurance does not place all financial responsibilities onto this practice, and you will be held accountable for any unpaid balances by your plan.

Although we are contracted with most insurance carriers, our services may not be covered by your particular insurance plan. Being referred to our practice by another physician does not necessarily guarantee that your insurance will cover our services. Please remember that you are 100 percent responsible for all charges incurred: your physician's referral and our eligibility verification of your insurance benefits are not a guarantee of payment.

We highly recommend you also contact your insurance carrier and check into your coverage for medical benefits coverage. Do not assume that you will not owe anything if you have more than one insurance policy.

FINANCIAL RESPONSIBILITY AGREEMENT

By signing below, I attest that:
My name, address, telephone number, and insurance information have been reviewed with a representative from Janigian Retina Associates and that it is true and correct. I agree to be financially responsible for any services provided by Janigian Retina Associates if the insurance is not correct, services are not covered by my plan, or the required authorizations or referrals have not been obtained.

I agree to inform Janigian Retina Associates of any changes to the above information after this date and understand that I will be financially responsible for any changes if I fail to update my information with the practice.

_____

Patient Name – Please Print

_____ _____

Signature of Patient or Representative Date

Updated 01/01/2018