retinaOC
Retina Orange County, Inc.
Orange County's Most Advanced Retinal Care

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Statement of Patient Financial Responsibility
Retina Orange County, Inc. appreciates the confidence you have shown in choosing us to provide for your health care needs. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill.

You are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. We expect these payments at time of service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. If your insurance carrier denies any part of your claim, or if you or your physician elects to continue past your approved period, you will be responsible for your balance in full.

I have read the above policy regarding my financial responsibility to Retina Orange County, Inc., for providing ophthalmology and medical services to me or the above named patient. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to Retina Orange County, Inc., the full and entire amount of bill incurred by me or the above named patient; or, if applicable any amount due after payment has been made by my insurance carrier.

Guarantor to sign (If guarantor is not the patient).

Co-Pay Policy
Some health insurance carriers require the patient to pay a co-pay for services rendered. It is expected and appreciated at the time the service is rendered for the patients to pay at EACH VISIT. Thank you for your cooperation in this matter.

Consent for Treatment and Authorization to Release Information
I hereby authorize Retina Orange County, Inc., through its appropriate personnel, to perform or have performed upon me, or the above named patient, appropriate assessment and treatment procedures.

I further authorize Retina Orange County, Inc., to release to appropriate agencies, any information acquired in the course of my or the above named patient's examination and treatment.

Cancellation / No Show Policy
We understand there may be times when you miss an appointment due to emergencies or obligations to work or family. However, we urge you to call 24-hours prior to canceling your appointment.

I understand if I no show for an appointment, then prior to scheduling another appointment, I will need to place a valid credit card on file. Should you no show for that follow up appointment, a $150 penalty charge will be applied. Should you no show for three appointments or cancel for a total of four appointments, I may be discharged from care.

The Practice will notify you in writing, via certified mail, if you are discharged from care. I have read and understand the above information, and I agree to the terms described.

Self-Pay
If I do not have health insurance, I will be responsible for services rendered here at Retina Orange County, Inc. I agree to pay Retina Orange County, Inc., the full and entire amount of treatment given to me or to the above named patient at each visit.