Retina Consultants

Diseases and Surgery of the Retina and Vitreous
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ANNUAL PATIENT RESPONSIBILITIES

Patient _____

Thank you for choosing Retina Consultants. We are committed to providing you with excellent care and treatment. We ask that you read and acknowledge the following Patient Responsibilities prior to starting treatment with us.

- I acknowledge responsibility for the payment of services you render to me. I understand that the payment for those services is due at the time of service unless other financial arrangements have been made prior to treatment. I understand that I should notify the appropriate staff in your Department of a change in my insurance coverage.
- I understand that I am responsible for any co-payments and visit fees incurred (exhausted benefits, deductibles, etc.) that are not reimbursed by my insurance provider. I understand that payment of those fees is due at the time of service.
- I understand that my appointment is a time exclusively reserved for me, and unless I call at least 24 (twenty-four) hours before my scheduled appointment I will be considered a no show. I understand that if I am considered a no show, I will be charged a $30.00 cancellation fee.
    - I understand that if I am not complying with the mutually agreed upon treatment plan or if I am disruptive or inappropriate towards any of the staff, my clinician may request to discontinue treatment.
    - I understand you reserve the **right to refuse to provide future services** should I demonstrate a history of no shows and/or late cancellations.

I have read and fully understand the above policies regarding patient care and payment responsibility.

To be signed annually by the patient.

Patient/Parent or Guardian's Signature:

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Date:

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