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## **AUSTIN RETINA ASSOCIATES FINANCIAL POLICY AGREEMENT**

We are dedicated to providing the best possible care and medical service to you and regard your complete understanding of your financial responsibilities as an essential element of your care. The following is our financial policy, and by accepting care from Austin Retina Associates, PA ("ARA"), you agree to be bound by this policy. This form cannot be modified by the patient/guardian without our written consent. Your signature acknowledges agreement to this policy, which is required prior to services being provided.

### **PROOF OF INSURANCE AND IDENTITY**

- For each appointment, you are required to present your current insurance card(s) and a valid photo ID. It is your responsibility to notify our practice regarding any insurance or address changes.

### **PAYMENT IS DUE AT THE TIME OF SERVICE**

- Unless other arrangements have been made in advance by either you or your health insurance carrier, full payment is due at the time of service. For your convenience we accept VISA, MasterCard, Discover and American Express.

### **PATIENTS WITH OUT-OF-NETWORK INSURANCE PLAN**

- If you have insurance coverage with a plan for which we do NOT have a contract or prior agreement, payment for your care and treatment is due at the time of service.

### **PATIENTS WITH IN-NETWORK INSURANCE PLAN**

- ARA is contracted with many insurers and health plans to accept assignment of benefits. As contracted Providers, we will send a claim to your insurance or health plan, and at the time of service will only require you to pay the authorized co-payment, deductibles and/or coinsurance. However, if after your insurance or health plan adjudicates the claim and a balance remains owe on your account for the service, you agree to pay the remaining amount owed upon receipt of a statement from ARA for the balance.
- In the event your insurance or health plan determines a service is "not covered," you will be responsible for the complete charge for ARA's service. Payment is due upon receipt of a statement from our office for the amount owed.
- If your insurance or health plan is one that we have an agreement with, but you do not present your insurance card at the time of service, you will be required to sign a waiver, your record will be recorded as "self-pay", and payment in full by you will be required at the time of service.



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- If it is discovered that you did not present the correct insurance or health plan ID card at the time of service, you will be responsible for the charges if they are denied by your correct insurance or health plan.
- Some insurance or health plans require an official referral/authorization number or form to be presented to ARA prior to your service. If the patient seeks medical services without this authorization in place prior to services being provided, you will be required to sign a waiver, and full payment by you will be collected at the time of service. It will be your responsibility to seek reimbursement, if any, from your insurance or health plan.

#### **PROMPT PAY DISCOUNTS**

- Austin Retina benefits from administrative cost savings from payment by patients at the time of services. As a result, patients will be eligible for the then applicable discount being provided by ARA. Patients are not eligible for discounts if they have outstanding balances from prior services that are still owed to ARA.

#### **MINOR PATIENTS/ WARDS**

- Parent/ guardians of the minor/ wards are responsible for payment of the bill for services.
- Payment arrangements must be made in advance for unaccompanied minors.

#### **COLLECTION OF UNPAID BALANCES**

After reasonable efforts to collect unpaid balances owed to ARA are completed, which shall be determined in ARA's sole discretion, ARA may seek the assistance of a collection agency or lawyer to obtain payment of all amounts owed ARA. If such is required, the patient shall be responsible for all reasonable collection expenses to include, but not limited to, collection agency expenses, attorney's fees and expenses, expert fees, and costs of court. Sole and exclusive venue for any dispute regarding amounts owed by you for yourself or a minor/ ward (as parent or guardian) shall be solely and exclusively in the federal, state and county courts of Travis County, Texas. If you have any questions regarding your balance, please call our billing office at (512) 451-0103.

#### **GENERAL NOTES REGARDING ARA'S FINANCIAL POLICY**

- If, after the patient's insurance or health plan makes a payment and a credit balance results on the patient's account, the credit balance will first be applied to any other balances due by the patient to ARA. After all amounts owed to ARA are paid, a refund will be issued within 30 days from the date the credit balance is identified.
- Requests for copies of medical records, and completion of FMLA or other forms, are billable to the patient as patient-responsible fees. Please request our separate form regarding fees for



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copies of records/forms.

**PATIENT ACKNOWLEDGEMENT**

I have read and understand the financial policy of ARA and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by ARA.

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**Printed Name of the Patient**

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**Signature of Patient or Responsible Party**

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**Date**