T. S. Melki, M.D., PA *K.K. Yee, M.D.*

www.retinaone.com

Diplomate of the American Board of Ophthalmology
Diseases & Surgery of the Retina & Vitreous

Patient Financial Responsibility

This is an agreement between The Retina center of Washington and the Patient/Guarantor named on this form.

Insurance: Insurance is a contract between you and your insurance company. In some cases we are not contracted with your insurance company and therefore we are not part of the contract. RCW will bill your insurance company as a onetime courtesy and if they do not pay the financial responsibility is yours. In order to properly bill your insurance company we require that you disclose all insurance information including primary, secondary and tertiary insurance information. Failure to provide complete and accurate insurance information may result in patient responsibility for the entire bill. Although we estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. If RCW is not contracted with your insurance company, you agree to pay any portion of the charges above the usual and customary allowance. If insurance pay you directly, you are responsible for payment and agree to forward the payment to RCW immediately. If your insurance company requires a referral and/or preauthorization, you are responsible for it and we will assist in the preauthorization process. Failure to obtain the referral and/or preauthorization may result in no payment from the insurance company, and the balance will be your responsibility.

Payment Options for In-Network Insurance:

A. You are required to pay your deductible, co-pay and any out -of-pocket portions at the time of service by cash, check or credit card.
B. If you choose to pay for all of your treatment in full at the time of service, we will promptly issue a refund for any credit balance when the insurance pays.

Payment: Unless we approve other arrangements in writing, the balance on your statement is due upon receipt. Approval is required for an extended payment arrangement. If payment is not received, we reserve the right to refuse future appointments on delinquent accounts.

Monthly Statement: If there is a balance on your account you will receive a monthly statement.

Medicare/Medicaid: We participate with Medicare and Maryland Medicaid. We agree to bill and accept the discounted reimbursement for both programs. There may be services rendered and supplies that are not covered by Medicare and therefore require an Advanced Beneficiary Notice (ABN) be signed by the patient/Guarantor. By signing the ABN, you understand that you are financially responsible for payment of those services.

Missed Appointments: We require 24 hours notice if you cannot make your appointment. If you are a "No-Show" a $50 fee will be billed and must be paid before rescheduling.

Returned Checks: A $35.00 fee will be assessed on any returned checks by the bank.

Past Due Accounts: If your account becomes past due, we will take necessary steps to collect this debt. If we refer your account to a collection agency you will be responsible for all associated collection fees, lawyer's fees and court cost.

Patient name: _____

Responsible Party: _____ Relationship: _____

Signature: _____ Date: _____

15020 Shady Grove Road, Suite 302
Rockville, Maryland 20850
(301) 279-9123

Georgetown University Hospital
3800 Reservoir Road, N.W., Lower Level
Pasquerilla Healthcare Center
Washington, DC 20007
(202) 944-5051

1715 N. George Mason Drive, Suite 101
Arlington, Virginia 22205
(703) 522-2366

Fax: (301) 279-6828 M.E.I. Email: general@retinaone.com