CORESIGHT Neuro-Ophthalmology LLC

13400 N. Meridian Street, Suite 283, Carmel Indiana 46032
Tel: 317 798 0040 Fax: 1844 232 5030

Financial Agreement Part 1

Financial Agreement: I agree that I will pay my account in full at the time service is rendered or pay within thirty (30) days of all charges established by Coresight Neuro-ophthalmology LLC, for services rendered to me or my dependent. This includes any charges that a third-party payer may determine to exceed usual and customary limits. I acknowledge all unpaid balances should be paid before next follow up visit, failure to do so may result in my account being sent to collection and my care with Coresight terminated without prior notice. I acknowledge that Coresight does not accept other financial arrangements. *Please review collection section*.

Copayments/Deductibles/Out of Pocket: If copayments and/or if I have not met my deductible/Out of Pocket maximum for the year designated by my insurance company or health plan, I agree to pay my copayment or facility fee to Coresight, **at the time of service**.

Collections: I understand and acknowledge that if any unpaid amounts owed by me are assigned to a third party for collection, I will be responsible for paying attorney fees, interest, court costs, and other costs of collection, including but not limited to collection agency fees. Also, **Coresight will no longer provide me with any medical services, without prior notice.**

Cancel/Reschedule Appointments: Coresight Neuro-Ophthalmology LLC, requires **48 hours**' notice to change or cancel a scheduled appointment. Failure to comply with this policy will result in a non-refundable charge of $**40** to be paid before your next appointment is scheduled.

Returned Check Fee: I understand and agree to pay a **$35** service charge to Coresight Neuro-Ophthalmology LLC, for any checks returned for insufficient funds.

Acknowledgment: The insurance information I have provided is current and correct. **If I sign this form and the insurance card is found later to be outdated or invalid, or for whatever reason my insurance carrier decline to pay for any medical services or testing I receive through Coresight, (*including extended office visit time spent with Dr. Ridha)* I understand that I am responsible for paying for the services in full and will need to file with the insurance carrier myself.**

_____ _____

Patient's Name (print) **Patient's** Signature or Authorized Party

_____ _____

Subscriber's Name if other than patient (print) **Subscriber's** Signature

Relationship to Patient: Date:

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Financial Agreement Part 2

MEDICARE: I request that payment of authorized Medicare benefits be made on my behalf to Coresight Neuro-Ophthalmology LLC, for services furnished to me by Coresight Neuro-Ophthalmology LLC. I authorize and holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If another health insurance is indicated in the item 9 of the CMS-1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency show. Coresight Neuro-Ophthalmology LLC, accepts the charge determination of the Medicare carrier as the full charge, and I am responsible on for the deductible, coinsurance and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare Carrier.

MEDIGAP: I understand that if a MEdiGap policy or other health insurance is indicated in Item 9 of the CMS-1500 form or elsewhere on other approved claim forms, my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to Coresight Neuro-Ophthalmology LLC, if possible or otherwise to me.

OTHER INSURANCE: I understand that Coresight Neuro-Ophthalmology LLC, contracts with health care service plans. The undersigned agrees that I am individually obligated to pay the full charges at the time of service of all services rendered to me by Coresight Neuro-Ophthalmology LLC, if I belong to a plan that Coresight Neuro-Ophthalmology LLC does not have a contractual agreement.

REFUND POLICY: We only issue refunds in the form of personal checks that will be mailed to you. We will not directly refund FSA, HSA, HRA, company cards, or flexible spending health accounts.

_____ _____

Patient's Name (print) **Patient's** Signature or Authorized Party

_____ _____

Subscriber's Name if other than patient (print) **Subscriber's** Signature

Relationship to Patient: Date: