RONALD SACHS, M.D.
RETINA ASSOCIATES OF
NORTHWEST NEW JERSEY, P.A.

Medical and Surgical Diseases of the
Retina, Vitreous and Macula
Fax (973) 539-7576

8 Saddle Road (Suite 201)
Cedar Knolls, NJ 07927
(973) 539-3600

RETINA ASSOCIATES' FINANCIAL AGREEMENT

Please take a few moments to read our Financial Agreement. You will be asked to sign a form acknowledging receipt and acceptance of this agreement.

We are committed to giving you the best possible care, and we are pleased to discuss the details of the Financial Agreement with you at any time. Your clear understanding is important to our professional relationship. If you have questions or need assistance, please contact our Office Manager directly at the number above. Please keep this document with your medical records so you will have it for reference.

We believe medical professionals, not insurance companies, should decide your care. That's why our practice approaches insurance differently. We have chosen not to participate with certain insurance plans because they compromise the level of quality care that we are committed to providing. We practice medicine based on what you need, not on what an insurance company dictates. Please see our Office Manager for all the names of insurance companies we participate with. If we do not participate with your insurance company, we will utilize your out-of-network benefits option.

INFORMATION FOR ALL PATIENTS

We will submit all claims on your behalf.

For your convenience, we accept payment by cash, check, money order, Visa or Mastercard.

We only send you a bill/statement when the insurance company has already processed the claim and outlined your financial responsibility or we have not had any response from your insurance carrier. If you receive a bill from us, our records indicate that the balance on the account is your responsibility. If you have a question about a bill, call our Office Manager.

PLEASE DO NOT IGNORE YOUR STATEMENTS!

Our representatives are available to help with payment arrangements or budget plans if you contact us immediately. Failure to respond to repeated communications from our office may result in discharge from the practice and/or involvement of an outside

collection agency. If a collection agency is involved, you will be responsible for all costs. This includes the original balance due plus the collection agency fee.

This Financial Agreement explains the three different insurance categories: out-of-network insurance, in network (Medicare) and self-pay (no insurance). Please read the category that applies to you CAREFULLY.

1. OUT-OF-NETWORK INSURANCE

We are not participating providers with your health plan, therefore, we are considered to be out-of-network providers. Most insurance products have optional "out-of-network" benefits (traditional, PPO or POS plans). Out-of-network benefits still provide coverage for physician services. A few plans do not include coverage for "out-of-network" physicians. These types are usually very strict HMO plans.

Insurance with an "out-of-network" option:
Office visits: Payment in full for the office visit is required at the time of the appointment. Our initial consultation fee ranges from $250-$500. Our follow up office visit fee ranges from $100-$350. Office diagnostic testing ranges from $100-$500. Office laser surgery and out patient hospital surgery will be discussed with you individually prior to surgery. At times, we may collect partial payment prior to a procedure.

Unfortunately, some insurance carriers will not send payment directly to your physician. All payments/explanations of benefits are sent to the patient/guardian. When you receive an explanation of benefit/payment for a service rendered by Retina Associates, contact our Office Manager **IMMEDIATELY. DO NOT WAIT** until you receive a statement or phone call from us.

We are not always notified by your insurance carrier when your claim is processed. As a courtesy to our patients, we bill your insurance company. Please give us the same courtesy and contact us as soon as you receive any correspondence or payment regarding a service we performed for you.

After you contact us, we will be happy to provide you with a statement for your records. Unless you have prepaid the charges, you will be required to forward the endorsed check and the explanation of benefits directly to us.

2. MEDICARE PART B

Retina Associates is a participating provider with Medicare Part B. If you have traditional Medicare Part B, we will not collect payment at the time of service. We will file your claim for you. After receiving payment from Medicare, unless you have secondary insurance, we will send you a statement showing the amount you are responsible for.

3. SELF-PAY/NO INSURANCE

Payment in full for the office visit is required at the time of the appointment. Our initial visit fee ranges from $250-$500. Follow-up visit fees range from $100-$350. If a diagnostic test, procedure or surgery is necessary, payment arrangements, if needed, can be made with our Office Manager.

We firmly believe that a good doctor-patient relationship is based on understanding and open communication. Our staff will make every effort to clarify any misunderstanding you have concerning your balance. We hope to avoid payment disagreements. If you have questions or need assistance, please contact our Office Manger.

4. IN-NETWORK INSURANCE

If we are participating providers with your health plan, we are then considered "in-network" providers. We will submit insurance claims on your behalf to your insurance carrier.

Thank you for taking the time to read our policies.

RONALD SACHS, M.D.
RETINA ASSOCIATES OF
NORTHWEST NEW JERSEY, P.A.

Medical and Surgical Diseases of the
Retina, Vitreous and Macula
Fax (973) 539-7576

8 Saddle Road (Suite 201)
Cedar Knolls, NJ 07927
(973) 539-3600

Acknowledgement of Receipt of Financial Policy

I acknowledge that I have been given a copy of Retina Associates' Financial Policy. Please take a few moments to read the enclosed Financial Policy.

I am aware of the fact that the Financial Policy explains the following information:

- ~ Payment policies
- ~ Out-of-network insurance
- ~ In-network insurance
- ~ Medicare
- ~ Self Pay / no insurance
- ~ Monthly statements

If I have any questions or concerns I will contact Retina Associates at (973) 539-3600

Signature:_____ Date:_____

Print Name:_____

Internal Use Only:

If patient or patient's representative refuses to sign acknowledgement of receipt of the Financial Policy, please document the date and time the notice was presented to patient:

Presented on (date & time):_____

Staff name & title:_____

Patient name:_____