Retina Center of Maine

Mark W. Balles, MD

195 Fore River Parkway, Suite 480

Portland, Maine 04102

Phone: 207-773-3938 Fax: 207-773-0801

www.retinamaine.com

Patient ID #: ______________ **Patient Name:** __________________________________

Financial Policy

Payment is due in full at the time service is rendered, including co-payments and deductibles. As a courtesy to our patients, we will bill your health plan for the services you have received with proof of insurance. Acceptable proof of insurance is a current health plan identification card containing all necessary billing information or appropriate internet verification. Patients who do not have health plan coverage will be expected to pay at the time of service.

Our Billing Staff will be glad to provide patients with an estimated fee for services prior to their examination. If additional charges would be required for treatment or diagnostic testing required, you will be advised of this during your visit.

If you have a worker's compensation claim, you must provide verification of worker's compensation and authorization for treatment prior to your appointment.

For your convenience, our practice accepts MasterCard, Visa, Discover, and American Express credit cards, personal as well as business checks, and cash payments. Checks returned for non-sufficient funds will be charged the bank's $25-dollar service fee. Overdue payments will be charged a 1.5% finance charge per month.

Delinquent accounts may be referred to a collection agency and may include additional collection fees added to your outstanding balance. If it becomes necessary to refer your account to collections, our understanding will be that you have chosen to discontinue your doctor patient relationship with our medical practice.

Patients may request our office to complete various forms for you such as short-term disability or family medical leave forms. Fees for providing this service is $50.00, we are glad to provide you with a copy of your medical record at no charge.

If you are unable to keep your scheduled appointment, please contact our office at least forty-eight (48) hours prior to your appointment to avoid a $50.00 missed appointment charge. This charge must be paid prior to being given a new appointment.

By signing below, I acknowledge that I have read and understand the Financial Policies of Retina Center of Maine.

Patient / Guarantor signature: ______________________________________ Date: ____________________