NEW ENGLAND RETINA CONSULTANTS, P.C.

DISEASE AND SURGERY OF RETINA AND VITREOUS

ANDREW LAM, MD DAVID LALLY, MD

SHILPA GULATI, MD HARI N. MYLVAGANAM, M.D.

AUTHORIZATION/FINANCIAL POLICY

INSURANCE: As a service to our patients, our office will submit fees for service to certain insurance companies. However, we do consider the patient (or guarantor) primarily responsible for the account. Once the claim has been processed by the insurance, if there is a balance remaining it is the patient's responsibility.
Additionally, the practice is not responsible for knowing what specific procedures or amounts are covered by your insurance policy or limits of your benefit coverage.

Please note that insurance cards MUST be presented at each visit, if your insurance changes, you must notify us prior to your services being rendered. If you do not present us with valid insurance information prior to, or at your appointment- you will be considered self-pay and will be charged for the appointment.

PAYMENT: Payment of co-payments, deductibles, outstanding balances and, self-pay amounts will be collected at the time service is rendered. For your convenience, we accept MasterCard, visa, discover, and American Express as well as personal checks and cash.

***Please note there is a returned check fee.**

INSURANCE REFERRALS: I acknowledge that I have sought the service of a specialist with or without being referred by my primary care physician. I understand that it is my responsibility to obtain an insurance referral if my insurance plan requires one. I further acknowledge that my signature below will hold me financially responsible for payment of services rendered if a referral is not received for my visit.

HIPAA: I acknowledge that the HIPPA (notice of privacy practice) is offered if I desire a copy of this document one will be provided to me.

I desire to have New England Retina consultants, P.C. provide me with professional services and agree to abide by this policy.

I authorize benefits be paid directly to New England Retina Consultants, P.C.

I agree to pay any balance due to the practice of New England Retina Consultants, P.C. within 30 days of receiving notification (which may be provided via mailed statements, letters, text, email/ and or telephone) of said balance.

I understand legal action may be taken if I fail to fulfill this contract, and will be responsible for all collection costs incurred, as well as any additional attorney's fees that may be assessed by court.

I hereby authorize photocopies of this form to be as valid as the original.

_____

Signature: Patient (or Guardian if patient is a minor or unable to sign) Patient name Date

PLEASE FILL OUT OTHER SIDE →

New England Retina Consultants, PC

Consent to Disclose Protected Health information

FAMILY, FRIENDS, OR OTHER REPRESENTATIVES

By signing below, I have authorized New England Retina Consultants, PC and/or the Retina Research Institute to disclose my Protected Health Information to, or discuss with, the following family members and friends:

Name	Relationship

Signature: _____ Date:_____

YOUR EMAIL: _____

EMERGENCY CONTACT: _____ TEL: _____

PRIMARY MEDICAL DOCTOR : _____ TEL: _____

RHEUMATOLOGIST: _____ TEL: _____

ENDOCRONOLOGIST: _____ TEL: _____

CARDIOLOGIST: _____ TEL: _____

OTHER DOCTORS: _____ TEL: _____

DR. _____ TEL: _____