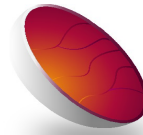


John P. Carlson, MD
Richard D. Pesavento, MD
Eric K. Chin, MD



Retina Consultants
of SOUTHERN CALIFORNIA

PATIENT INFORMATION PACKET

I. Patient Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Patient's: Date of Birth (required) / / Social Security # (required) _____

Phone Number _____ Email: _____

Referring Dr _____ **Primary Dr** _____

II. Insured Name (required if different than patient): _____

Address: _____

City: _____ State: _____ Zip: _____

Day Phone #: _____ Eve Phone #: _____ Relationship to Patient: _____

Insured's: Date of Birth (required) / / Social Security # (required) _____

III. Name of Insurance Company: _____

Claims Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____ Group or Policy #: _____ ID#: _____

***If patient is a minor, please add guarantor information below:**

Name _____ Relationship to Minor _____

Emergency Contact _____ Phone _____

<u>Redlands</u> 1895 Orange Tree Ln Ste. 204 (909) 796-3003	<u>Riverside</u> 9041 Magnolia Ave Ste. 207 (951) 7880-222	<u>Victorville</u> 15413 Anacapa Rd. Ste. #6B (760) 596-3950	<u>Hemet</u> 3953 W. Stetson Ave (951) 788-0222	<u>Murrieta</u> 25395 Hancock Ave. Ste. 100 (951) 788-0222
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Retina Consultants of Southern California
Financial Policy (“RCSC”) page 1 of 2

We are committed to providing you with the highest level of service and quality care. Our office strives to help you receive the maximum allowable benefits of your medical insurance. Ultimately, however, any and all financial liability rests with the patient.

Our office participates with most major insurance plans. We provide Medical and Surgical retinal care to our patients, as opposed to routine eye exams. If you have a managed care plan (HMO) a referral is required for every visit in order for services to be covered under your plan. If a referral has not been received, you will have the option to reschedule your appointment or pay for your treatment privately at the time services are rendered.

If there is any change in your insurance coverage and we are not notified prior to your visit then you will be responsible for all incurred fees. This includes changes in your HMO Managed Care Plan or Medical Group.

It is the patient's/parent's/guardian's responsibility to:

- Be familiar with the benefits of your plan, including co-pays, co-insurance and deductibles.
- Make sure a copy of your current insurance card is on file.
- Notify our office of any changes including insurance changes, address, phone numbers and employer.
- Be aware our office policy is that copays are due at time of service and will not be billed. We accept cash, checks, Visa, Discover, Master Card, American Express and Care Credit.

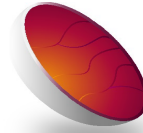
We appreciate prompt payment in full for any outstanding balance. If you are unable to pay the balance in full, please notify our billing department immediately to discuss payment plan options. All returned checks will result in a \$35 fee, which will be added to your account and must be paid before the next visit. Any balance remaining on your account 90 days past due will automatically incur a 25% increase on the balance outstanding if being forwarded to a collection agency.

I understand if I have an unpaid balance to RCSC and do not make satisfactory payment arrangements or fail to make payments as arranged, my account may be placed with an external collection agency. I will be responsible for reimbursement of any fees from the collection agency, including all costs and expenses incurred collecting my account, and possibly including reasonable attorney's fees if so incurred during collection efforts.

PRINT NAME

SIGNATURE

DATE



PATIENT INFORMATION PACKET

Retina Consultants of Southern California Financial Policy (“RCSC”) page 2 of 2

In order for RCSC or their designated external collection agency to service my account, and where not prohibited by applicable law, I agree that RCSC and the designated external collection agency are authorized to (i) contact me by telephone number(s) I am providing, including wireless telephone numbers, which could result in charges to me, (ii) contact me but sending text messages (message and data rates may apply) or emails, using any email address I provide and (iii) methods of contact may include using pre-recorded/artificial voice message and/or use of an automatic dialing device, as applicable.

For all services rendered to minor/dependent patients, we will look to the adult accompanying the patient and/or the parent or guardian with whom the child resides for payment/ In cases of separation or divorce, when presenting insurance cards for a dependent enrolled under a subscriber other than you, please be prepared to supply their name, address, phone number, date of birth and social security number. We request that you inform the subscriber that their insurance has been used.

I have read and understand the above financial policy.

PRINT NAME

SIGNATURE

DATE

<u>Redlands</u> 1895 Orange Tree Ln Ste. 204 (909) 796-3003	<u>Riverside</u> 9041 Magnolia Ave Ste. 207 (951) 7880-222	<u>Victorville</u> 15413 Anacapa Rd. Ste. #6B (760) 596-3950	<u>Hemet</u> 3953 W. Stetson Ave (951) 788-0222	<u>Murrieta</u> 25395 Hancock Ave. Ste. 100 (951) 788-0222
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