

**OFFICE POLICIES/  
FINANCIAL GUARANTEE**

Welcome to our practice. In order to better serve you we would like you to review our **office policies**:

- Due to our retina specialty practice emergency patients must be given top priority, which could delay your appointment. We do not treat general ophthalmologic conditions because of the nature of our specialty. Therefore, if you are referred to our practice by a general ophthalmologist for specialty care, once the medical problem is assessed and treated you will be referred back to the referring physician.
- **Many insurance companies require prior authorization** before you can be examined by the doctor. **Please make sure that you provide our office with a copy of your authorization prior to being seen.** Insurance co-payments are always due at the time of service.
- **If you are private pay and have no insurance, payment is due in full at the time of service.** Unless a prior written payment agreement has been established with the office.
- By signing this form you are authorizing North Bay Vitreoretinal Consultants to bill your insurance company as listed on the **PATIENT INFORMATION SHEET** on your behalf. **We will bill up to two insurance companies for you** but require all appropriate information. Please provide the claims address, all policy ID #'s, and subscriber information. **Most insurance companies have a claim filing time limit, usually up to 3 months. If you do not provide accurate information in a timely fashion and we are unable to bill them, all charges will be your responsibility.**
- **For patient forms** please allow at least 2 weeks. Please note that all medical record requests will require a signed release from the patient **before** processing can take place. Please be advised that if records are not going directly to a physician there will be a charge.
- Please identify **individuals with whom you authorize us to share your medical information** as needed:  
1) \_\_\_\_\_ 3) \_\_\_\_\_  
2) \_\_\_\_\_ 4) \_\_\_\_\_
- \_\_\_\_\_ My initials here acknowledge the HIPAA Privacy Notice is available for viewing in the office and a copy is available upon request.

*Your signature indicates that you have read and understand our office policies and are aware of your responsibility to obtain prior authorizations, insurance eligibility, and pay your co-payments at the time of service. We will be more than happy to discuss any of these issues with you in more detail if you require more information.*

\_\_\_\_\_  
(Print first and last name)

\_\_\_\_\_  
(Signature above)

By \_\_\_\_\_  
(Representative's first and last name)

\_\_\_\_\_  
(Signature of Representative)

\_\_\_\_\_  
(Representative's address)

\_\_\_\_\_  
(Representative's relationship to patient) & (Reason for Representative)