RETINA
SPECIALISTS OF TAMPA

Patient Financial Agreement Form

Patient name: _____

Each New Year, your insurance plan resets your deductible. In order for your insurance plan to pay for services provided, you will have to meet the threshold of out-of-pocket payments. By initialing below, you are stating that you understand all charges set by your insurance are due at the time of service. **Even if this does not apply to you, please initial.**

_____ (Patient/Guardian Initials)

If you are a Medicare patient, please be advised that the Medicare deductible for 2022 is set at **$233.00**. In order for Medicare to pay for serviced provides, you must meet your deductible completely for the year. By initialing below, you are stating that you understand all charges set by your insurance are due at the time of service. **Even if this does not apply to you, please initial.**

_____ (Patient/Guardian Initials)

If you are a self pay patient, please be advised that the price for injections for 2022 has changed (see below). By initialing below, you are stating that you understand the charges, set and enforced by Retina Specialists of Tampa, are due at the time of service. **Even if this does not apply to you, please initial.**

_____ (Patient/Guardian Initials)

New Injection Prices:

- Full exam with injections in one eye (including diagnostic testing) – **$200**
- Full exam with injections in both eyes (including diagnostic testing) – **$280**

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Referral Agreement

Patient name: _____

Please be advised:

Many HMO and insurance plans require referrals and authorizations to see a specialist. We make every effort to make sure that these authorizations and referrals are done on your initial appointment and will work with your primary care physician to obtain these. However, any subsequent and follow up appointments will be the patients responsibility.

Your signature below acknowledges that if your insurance company refuses to pay because of lack of referral or authorization you will be responsible for any fees. **Even if this does not apply to you please sign below.**

_____

Patient Signature

_____

Date