



Northern Illinois Retina 2026 Financial Policy Agreement (FPA)

Please sign to indicate that you understand the following:

I agree to pay my copay and balance at each visit. Payment of all insurance co-payments, co-insurance and deductible portions are to be paid in full at each visit and prior to any surgery. We accept cash, checks and major credit cards (3% surcharge on credit card payments).

My bill is my responsibility, whether my insurance pays or not. Your insurance policy is a contract between you and your insurance company. As a courtesy, Northern Illinois Retina will file a claim for each visit with your insurance carrier(s) one time and will appeal one time if the claim is denied. After this, the amount that should have been covered by your insurance will be your responsibility to pay Northern Illinois Retina and to contact your insurance to be reimbursed. You must provide up-to-date insurance information to our office. If the insurance information you provide is incorrect or inactive, you will be responsible for payment of the visit.

If I am a self-paying patient- I agree to pay the total of services rendered at each visit. A self-pay discount will apply to all fees paid in full. Limited insurance or high-deductible patients should expect to pay a minimum of \$250 on the initial visit and to pay at each visit until deductible is met. For extended treatments, payment arrangements are available and can be made with the billing staff.

Interest will be applied to my balance after 30 days if unpaid. We cannot hold patient balances for extended periods of time. Patient balances unpaid for more than 30 days will incur 3% interest fees each 30 days of nonpayment and will be turned over to a third-party collection agency after 90 days. Additional fees will be incurred in the collection process.

I may need prior authorization from my insurance. Some insurance companies require an authorization or referral prior to your visit. It is your responsibility to know if your insurance requires this. Please bring all referrals to the billing department. We will request prior authorization if needed. If your insurance has not given authorization for your visit, it may need to be rescheduled.

I understand that failure to maintain a current account with Northern Illinois Retina may result in further non-emergent medical treatment not being provided and/or dismissal from the care of Northern Illinois Retina.

By signing below, I acknowledge receipt of this FPA and agree to the financial responsibilities it lists.

X _____ X _____
Signature of patient or responsible party Patient Name- Please Print Date