

Advanced Patient Notice

I understand that my physician owns Augusta Retina-Laser Surgicare, an Ambulatory Surgery Center. I understand that I am free to choose another facility in which to receive the services that may be ordered by my physician. I also agree to adhere to the treatment plans recommended by my doctor, and to treat all staff members with respect.

My physician has determined that some procedures can be performed at Augusta Retina Laser Surgicare. I understand that if an emergency medical condition should occur while being treated at this facility, I will be transferred to the closest hospital for further evaluation and treatment. I understand that if I have an advance directive or living will, the ambulatory surgical and treatment facility will still transfer me to the closest hospital.

Assignment and Release

I understand, I (or my dependent) have insurance coverage and assign directly to Southeast Retina, all insurance benefits, if any, otherwise payable to me for service rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all Insurance submissions. If I choose not to file insurance, I understand I am responsible for paying the full non-discounted fee for the services performed. We do file insurance claims for participating plans. Please bring your insurance card with you for every appointment. A copy of your card is required as per our Company policy to file claims to your insurance carrier.

Financial Agreement

All co-payments and deductibles are due at the time of service.

I acknowledge that it is my responsibility for the fees listed above and that copays and deductibles are due at the time of services.

I understand should there be a payment plan, all terms of the payment agreement need to be honored. I understand that should my account be placed in an outside collection agency, I agree to the terms that I may be charged all reasonable collection fees.

Patient/ Responsible Person name:

Patient or Responsible Person Signature: _____