RETINA HEALTH INSTITUTE S.C.

Vision Redefined
2320 N Huntington Rd., Algonquin, IL, 60102
847-488-1030 (Office) 847-488-0677 (Fax)

www.retinahealthinstitute.com

LAST NAME:	FIRST NAME:	DOB:

REASON FOR VISIT: *(Please tell us a little regarding your visit today)*

Personal Medical History

Condition	Yes	No	Comments
CONSTITUTIONAL *e.g. fever, heat stroke, weight loss, weight gain, unusually tired, etc.*			
EAR/NOSE/THROAT *e.g. hard of hearing, stuffy nose, earache, cough, dry mouth, etc.*			
CARDIOVASCULAR *e.g. high blood pressure, racing pulse, chest pain, exercise intolerance, A fib, blood thinner use, etc.*			
LUNG (RESPIRATORY) *e.g. congestion, wheezing, shortness of breath, cough - productive/blood, asthma, etc.*			
GASTROINTESTINAL *e.g. stomach upset, diarrhea, constipation, hernia, ulcers, pain/cramps, acid reflux, etc.*			
MUSCULOSKELETAL *e.g. muscle pain/cramps, joint pain swelling, stiffness, etc.*			
GENITOURINARY *e.g. painful urination, frequent urination, burning, impotence, incontinence, infections, etc.*			
GYNECOLOGICAL (FEMALE ONLY) *e.g. pregnancies, menstrual problems, ovarian & uterine conditions, etc.*			

BREAST (FEMALE ONLY)			
NEUROLOGICAL *e.g. numbness, weakness, headaches, paralysis, seizures, tremors, tingling, etc.*			
PSYCHIATRIC *e.g. depression, anxiety, mood swings, insomnia, hallucinations, disorientation, etc.*			
BLOOD/LYMPHATIC *e.g. high cholesterol, anemia, blood disorders, leukemia, prolonged bleeding, etc.*			
SKIN *e.g. itching, rash, infection, ulcer, tumor/growths, warts, excessive dryness, etc.*			
CANCER			
ALLERGIC/IMMUNOLOGIC *e.g. recurrent infections, hay fever, food allergy,* *drug sensitivity, hives, redness, itching, etc.*			
ENDOCRINE *e.g. diabetes, thyroid problems, fatigue, hair loss, hot/cold intolerance, etc.*			

MAJOR ILLNESSES/HOSPITALIZATION ☐ Yes ☐ No	
SURGERIES ☐ Yes ☐ No	

If you are diabetic:

YEAR OF DIAGNOSIS:	**RESULT/TIME OF LAST BLOOD SUGAR:**
LAST HEMOGLOBIN A1C:	**DOCTOR & CONTACT INFORMATION:**
TREATMENTS:	

Family History *(Parents, Siblings, or Grandparents only)*

EYE DISEASE	
☐ Glaucoma ☐ Cataract ☐ Retinal Detachment ☐ Blindness	☐ Macular Degeneration ☐ Macular Dystrophy ☐ Retinitis Pigmentosa ☐ Retinal Degeneration
SYSTEMIC DISEASE	
☐ Diabetes ☐ Cancer ☐ Heart Disease	☐ Hypertension ☐ Arthritis ☐ Other:

Personal Social History

MARITAL STATUS:	**LIVING ARRANGEMENTS:**
TOBACCO USE: ☐ Never ☐ Current Everyday Use ☐ Current Some Day Use ☐ Former Use ☐ Status Unknown ☐ Other:_____.	
ALCOHOL USE: ☐ Never ☐ Current Everyday Use ☐ Current Some Day Use ☐ Former Use ☐ Status Unknown ☐ Other:_____.	
RECREATIONAL DRUG USE: ☐ Never ☐ Current Use ☐ Former Use ☐ Status Unknown ☐ Other:_____.	
OCCUPATION(S):	**OCCUPATIONAL EXPOSURE: ☐ Yes ☐ No**
RECENT TRAVEL: ☐ Yes ☐ No	
Have you been exposed to Venereal Disease/Sexually Transmitted Disease? ☐ Yes ☐ No	
Are you pregnant? (Female only) ☐ Yes ☐ No	

Personal Ocular History

DO YOU WEAR GLASSES/CONTACTS? **➔ HOW LONG HAVE YOU USED THEM?**
DO YOU HAVE PROBLEMS WITH VISION?
HISTORY OF EYE TRAUMA?
DO YOU HAVE ANY EYE CONDITIONS? (CATARACT, GLAUCOMA, ETC.)
HAVE YOU HAD EYE SURGERY? **IF YES, WHEN?**

LAST EYE EXAM:
OTHER EYE CONDITIONS:

MEDICATIONS: *List ALL medications you are CURRENTLY taking or attach list for technician. (include all herbals, vitamins & supplements)*

List drug, dose, how often taken and any other relevant details.

IF MEDICATION LIST IS TOO LONG THEN PLEASE ATTACH A SEPARATE SHEET

ALLERGIES: *List ALL allergies, severity, reaction and treatment information*

PREFERRED PHARMACY: *Please provide name and location of preferred pharmacy*

SIGNATURE **DATE**

PRINTED NAME

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PATIENT INFORMATION				
LAST NAME*		FIRST NAME*		MIDDLE INITIAL
IF MINOR, NAME OF RESPONSIBLE PARENT				
DOB*	SOCIAL SECURITY #		DRIVERS LICENSE #	
HOME ADDRESS*			APT/SUITE #	
CITY*		STATE*	ZIP*	
HOME #*	DAYTIME #		FAX #	
MOBILE #*	EMAIL ADDRESS*		☐ FEMALE* ☐ MALE*	
OCCUPATION	EMPLOYER		PHONE #	
ADDRESS	CITY	STATE	ZIP	

IF APPLICABLE, NAME OF SPOUSE/DOMESTIC PARTNER		
LAST NAME	FIRST NAME	MIDDLE INITIAL

IF PATIENT IS LIVING IN A NURSING FACILITY*		
NAME OF FACILITY*		
ADDRESS*		ROOM #*
CITY*	STATE*	ZIP*

CONTACT INFORMATION FOR RESPONSIBLE PARTY/SPOUSE/PARENT/POA (If info same as above, leave blank)		
LAST NAME	FIRST NAME	MIDDLE INITIAL
SOCIAL SECURITY #	RELATIONSHIP TO PATIENT	
ADDRESS	CITY	ZIP
HOME #	DAYTIME #	FAX#
CELL #	EMAIL ADDRESS*	

PATIENT REFERRAL INFORMATION			
PATIENT REFERRED BY*			**PHONE #**
ADDRESS	**CITY**	**STATE**	**ZIP**
PRIMARY CARE PHYSICIAN*			**PHONE #**
ADDRESS	**CITY**	**STATE**	**ZIP**

EMERGENCY CONTACTS (PLEASE FILL IN TWO WITH DIFFERENT CONTACT INFORMATION)			
NAME	**RELATIONSHIP**		**PHONE #**
ADDRESS	**CITY**	**STATE**	**ZIP**
NAME	**RELATIONSHIP**		**PHONE #**
ADDRESS	**CITY**	**STATE**	**ZIP**

EDUCATION, LANGUAGE & MISCELLANEOUS	
HIGHEST LEVEL OF EDUCATION	**PREFERRED LANGUAGE**
DO YOU NEED AN INTERPRETER?	
ETHNICITY:	**RACE:**

WHO CAN WE SHARE YOUR INFORMATION WITH?

Patient:_____ **Date:**

Patient Representative / Parent: _____ **Date:**

For patients requiring translation or verbal reading of the document, the reader/translator may document and sign below.

Reader / Translator: **Date:**

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BENEFITS ASSIGNMENT

Last Name	First Name	DOB

AUTHORIZATION FOR MEDICAL INFORMATION RELEASE - I authorize Retina Health Institute, S.C. to release to my insurance company, any medical information needed to determine benefits payable for related services.

AGREEMENT OF RESPONSIBILITY – I understand that professional services are rendered and charged to the patient. CO-PAY IS DUE AT THE TIME OF SERVICE (Co-insurance and deductibles may also be collected at the time of service). I understand I am financially responsible for charges not covered by my insurance company. I also agree to pay any outstanding balance, as well as attorney fees and costs to Retina Health Institute, S.C. if this matter is referred to collection.

RELEASE OF INFORMATION/ASSIGNMENT OF BENEFITS – I authorize use of this form for release of information needed to process claims to all my insurance companies. I permit a copy of this authorization to be used in place of the original. I authorize the provider to act as my agent in helping obtain payment from my insurance companies. I assign all rights and claims for reimbursement of expenses allowable under my insurance plan and authorize payment directly to the provider for services rendered. I understand I will receive monthly statements for any balance due by me. I also understand, full payment is required to be made on receipt of your 1st statement after insurance has met their obligation.

MEDICARE AUTHORIZATION – I request payment of authorized Medicare benefits be made on my behalf to Retina Health Institute, S.C., for any services provided to me by that physician/supplier. I authorize the holder of medical information about me to release to Medicare and its agents, any information needed to determine these benefits or benefits payable for related services.

I understand my signature requests payment to be made and authorize release of medical information necessary to pay claims. If 'other health insurance' is indicated in item 9 of the HCFA-1500 Form, or elsewhere on approved claim forms, or electronically submitted claims, my signature authorizes release of information to insurer or agency shown. In Medicare assigned cases, the physician/supplier agrees to accept the charge of determination of the Medicare carrier as the full charge – the patient is responsible for deductible, co-insurance and non-covered services. Co-insurance and deductibles are based upon the charge determination of the Medicare carrier.

MEDIGAP/SUPPLEMENTAL AUTHORIZATION - I request payment of authorized Medigap/Supplemental benefits on my behalf to Retina Health Institute, S.C., for any services furnished me by that physician/supplier. I authorize holder of my medical information to release to Medigap/Supplemental and its agents, any information needed to determine these benefits or the benefits payable to related services.

AUTHORIZATION – INSURANCE/FINANCIAL MATTERS - By my signature, I also authorize Retina Health Institute, S.C., to discuss financial/insurance matters on my behalf with those persons designated below (Please PRINT complete names & relationship):

PATIENT: **DATE:**

Attestation

I, _____, hereby give my consent to Retina Health Institute, S.C., to use or disclose, for the purpose of carrying out treatment, payment, or health care operations, all information contained in my patient record.

I acknowledge having received a copy of the Notice of Privacy Practices which contains a more complete description of the uses and disclosures of my health information. I understand that the practice has the right to change its Notice of Privacy Practices from time to time and that I may contact the practice at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so, to Retina Health Institute. I also understand that I will not be able to revoke this consent in cases where the physician has already relied on it to use or disclose my Protected Health Information.

I understand that, under the HEALTH Insurance Portability & Accountability Act of 1966 (HIPAA), I have certain rights to privacy regarding my protected health Information. I understand this Information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I understand that I may request in WRITING that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

PATIENT **DATE**

PATIENT REPRESENTATIVE / PARENT DATE

FOR OFFICE USE ONLY:

I attempted to obtain patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so:

Reason:

PRACTICE REPRESENTATIVE DATE

RETINA HEALTH INSTITUTE S.C.

PATIENT FINANCIAL RESPONSIBILITY FORM

Thank you for choosing Retina Health Institute ("RHI") as your healthcare provider. We are honored by your choice and are committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

Patient Financial Responsibilities

- The patient (or patient's guardian, if a minor) is ultimately responsible for the payment for his/her treatment and care.
- We are pleased to assist you by billing for our contracted insurers. However, the patient is required to provide us with the most correct and updated information about their insurance and will be responsible for any charges incurred if the information provided is not correct or updated.
- Patients are responsible for the payment of copays, coinsurance, deductibles, and all other procedures or treatment not covered by their insurance plan. Payment is due at the time of service, and for your convenience, we accept cash, check, and most major credit cards at our office.
- Patients may incur and are responsible for the payment of additional charges at the discretion of RHI. These charges may include (but are not limited to):
    - Charge for returned checks.
    - Charge for missed appointments without 24 hours advance notice.
    - Charge for extensive phone consultations and/or after-hours phone calls requiring diagnosis, treatment, or prescriptions.
    - Charge for the copying and distribution of patient medical records.
    - Charge for extensive forms completion.
    - Any costs associated with collection of patient balances.

Patient Authorizations

- By my signature below, I hereby authorize RHI, and the physicians, staff, and hospitals associated with RHI to release medical and other information acquired during my examination and/or treatment to the necessary insurance companies, third party payors, and/or other physicians or healthcare entities required to participate in my care.
- By my signature below, I hereby authorize assignment of financial benefits directly to RHI and any associated healthcare entities for services rendered as allowable under standard third-party contracts. I understand that I am financially responsible for charges not covered by this assignment.
- By my signature below, I authorize RHI personnel to communication by mail, answering machine message, and/or email according to the information I have provided in my patient registration information.
- If I fail to provide correct insurance information or have unpaid balances due to patient responsibility or lack of insurance payment, I consent to my account being sent to collections. I waive any right to hold Retina Health Institute liable for damages and accept responsibility for all associated collection costs.
- By my signature below, I authorize RHI to securely store my credit card information and only charge it should I have an outstanding balance or any leftover balance from a processed claim in the future. I am aware that the storage system used is fully compliant to the highest level of credit card storage security regulations. Once stored, I am aware that only the last 5 digits of my card are viewable by RHI personnel. I understand that I am responsible for all charges for services that I receive from RHI, and that if the patient responsibility portion of my charges (including charges applied to my deductible and/or coinsurance) is not paid in full within thirty (30) days following the receipt of the patient financial responsibility statement mailed from the RHI Billing Office, RHI will bill my stored credit card for the outstanding balance due.

I have read, understand, and agree to the provisions of this Patient Financial Responsibility Form:

Signature of Patient or Guardian Date

Waiver of Patient Authorizations

I do not wish to have information released and prefer to pay at the time of service and/or to be fully responsible for payment of charges and to submit claims to insurance at my discretion.

Signature of Patient or Guardian Date

RETINA HEALTH INSTITUTE S.C.

Medical Release of Information

Patient Name: _____ DOB: _____

I hereby give my consent and authorize to the following facility:

Retina Health Institute, SC
2320 N Huntington Rd
Algonquin, IL 60102
Tel: 847.488.1030 Fax: 847.488.0677

To have access to my;

Medical Records, Physician Notes, Laboratory Reports, Pathology Reports, Radiology Reports, Procedural/Operative Reports and Consultation Reports.

I understand that I may revoke this consent in writing at time, although not retroactively, and that upon fulfillment of the above request medical information or the lapse of one (1) year from the date of signature, whichever comes first, this consent will automatically expire without my expressed revocation. A photocopy of this authorization shall be as valid as the original.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I understand that I may inspect or copy the information to be used or disclosed as provided in 45 C F R 165.524. I understand any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. The patient's medical record is privileged information, which is protected by various State and Federal Laws. Such information may not be further disclosed to other persons or entities without a separate written authorization from the patients.

I understand that the information in my health record may include information relating to sexually transmitted diseases, such as the acquired immunodeficiency syndrome (AIDS), or Human Immunodeficiency Virus (HIV). It may include information about behavioral or mental health services, and treatment of alcohol and drug abuse.

Patient must sign unless he/she is a minor under 18 or is unable to sign. If signature is not of a patient, indicate the relationship to patient.

Patient Signature: _____ Date: _____

Relationship to Patient: _____

RETINA HEALTH INSTITUTE S.C.

NON-COVERED SERVICE FEES & PRIVATE PAY POLICIES

Thank you for choosing Retina Health Institute ("RHI") as your healthcare provider. We are honored by your choice and are committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our non-covered service fees. If you would like a bulleted summary of our non-covered service fees, please contact our office staff for a copy.

Cancellation and No-show Policy

Our office strives to make patient care a top priority. An integral part of providing our patients with the best care possible is patient compliance with appointments.

If you must cancel or reschedule your appointment, we ask that you please contact our office ***at least*** **24 business hours prior to your appointment time or on Friday for any Monday appointments.** A no-show fee will be assessed to the patient's account if 24 hours (or on Friday for a Monday appointment) is not provided for cancellation or if an appointment is missed with no notification. Multiple no shows or same-day cancellations will result in higher no-show charges for each missed appointment and may result in dismissal (or discharge) from the practice.

- There is a **$150 charge** for a missed new patient to establish care with our office. If a second initial visit is missed the appointment will not be rescheduled.
- There is a **$150 charge** for a missed procedure appointment including fluorescein angiogram, intravitreal injections, and lasers.
- There is a **$75 charge** for the first missed return or follow up appointment.
- There is a **$100 charge** for the second missed return appointment.
- If a third appointment is missed, the patient may be considered noncompliant with follow up, which may result in discharge from the practice and responsibility of combined no-show charges above.
- There is a $**25 charge** for failure to schedule a follow-up appointment prior to exit from the office.

No show fees are considered the responsibility of the patient and will not be billed to insurance companies or other medical billing agencies. All no-show fees must be paid in full before another appointment can be scheduled. Payments can be made in the office, over the phone with a credit/debit card, or mailed in to the office. Once payment is received, we are happy to reschedule an appointment for the first available time with your provider. We appreciate your understanding and cooperation with this policy.

Payment Policy

We file your insurance claims as a courtesy to you. Your insurance is a method of reimbursement for physician services. Having insurance is not a substitute for payment. Many insurance companies have fixed allowances or percentages based on your contract with them, not with our office. It is your responsibility to pay the deductible, co-insurance, co-payment, non-covered services, and any other balance not paid by your insurance. Our office asks that the amount left to patient responsibility be paid at the time services are rendered. Any additional balances not paid by the insurance company are ultimately the responsibility of the patient. Any balances left to patient responsibility are expected to be paid within 30 days of receipt of the first account statement for that balance. After the first statement a **rebill fee of $5** will apply to each statement sent, this fee applies to failure to update address on file prior to statements being sent to address on file.

If you have questions about insurance or billing, please Contact our office.

Past due balances will incur an account-maintenance fee once the balance is 30 days past due. After 60 days past due this new balance as well as any no-show fees will be forwarded to an outside collection agency. All additional costs incurred due to the delinquency of the account are the patient's responsibility. These costs may include billing fees, collection agency cost, which may exceed 50 percent of the balance, and/or attorney fees if applicable. The patient must then contact the agency rather than the office for any further payment arrangements.

Patients who provide checks with insufficient funds will incur a **fee of $75** and will no longer be permitted to pay by personal check. Failure to update insurance at the time of your appointment and subsequent denial of claim after submission will also result in **a fee of $300.**

Prescription Refill and Prior Authorization Policy

- We do not accept pharmacy prescription refill requests.
- Please request medication refills at your appointments, through our patient portal, or by calling the office and allow 72 business hours to process all prescription refill requests. Prescription refill requests outside of appointment time will result in a **$25 fee** as a telephone encounter is required to fulfill your request.
- If you are calling with a standard refill request and are an active patient (seen regularly) then the medication will be sent to the pharmacy without a return phone call to the patient.
- Per office policy you must been seen *at least* once a year for us to refill your medication. *Please check with the pharmacy prior to calling our office back to check on the refill as multiple phone calls to the office will slow the refill process down.*
- Our office will complete multiple Prior Authorizations (PA) per calendar year recommended treatments. If your insurance plan requires additional PAs or in the event of a change in insurance requiring a new PA, there is a **$100 annual PA fee**. If your PA is denied and the doctor must do a letter of appeal or medical necessity or a "peer to peer," a **$35 charge** will be added to the account. These will not be billed to insurance and will be the responsibility of the patient.

Patient Phone calls

Please allow 72 hours during the week for return phone call from clinical staff. Note we close at 5PM on Fridays. Please do not call more than 1 time per 24h hours. Excessive phone calls will result in additional fees to the patient. These are not covered by insurance. Please do not call AND send a portal message.

For faster response please use the patient portal. Please be considerate in your use of the portal and allow 24-48 weekday hours for a response. Please do not send a portal message and leave a voicemail. *Excessive portal use will result in charges that may not be covered by insurance*. The portal is not a substitute for a patient visit and cannot be used to manage new problems.

Please understand that an office visit may be required to follow up a portal concern.

If you have a medical emergency, please call 911 and go to the nearest emergency room.

Our physicians are on call after hours for emergencies only; please understand our office is charged for each after hours call. Please see refill policy above. Repeated calls or abuse of this system will be assessed a **$20 fee.**

If you are calling with a standard refill request and are an active patient (seen regularly) then the medication will be sent to the pharmacy without a return phone call to the patient. Please check with the pharmacy prior to calling our office back to check on the refill.

Forms and Documentation

We understand that your place of employment or other agency may require that you provide documentation outside of the clinical office note. We are happy to complete these for you but please understand that we do charge **a fee starting at $25 per page** and the time anticipated to complete it. Please allow at least 7-10 business days for this process. Forms are completed in the order they are received. There are some forms we will be unable to complete. You must have been seen within the last 6 months for form completion. Thank you for your understanding.

I have read, understand, and agree to the provisions of this Patient Financial Responsibility Form:

Signature of Patient or Guardian Date

PATIENT CONDUCT AGREEMENT

I [Print Name] _____do hereby certify that on this date [insert date] _____, I received a copy of this Patient Conduct Agreement for Retina Health Institute and have read and understand its contents. I understand that the rights or safety of other persons. I also understand that failure on my part to adhere to the expectations described in this Agreement may lead to the immediate and total suspension of healthcare services, to the full extent permitted under the law, and to possible civil and/or criminal action being initiated.

PROHIBITED BEHAVIOR INCLUDES BUT IS NOT LIMITED TO:

- Possessing firearms or any weapon on the clinical premises;
- Being intoxicated or under the influence of drugs, unless used as prescribed by a treating health care provider.
- Making non-consensual physical contact with real and /or perceived aggressive overtones toward RHI staff and/or others;
- Making verbal threats to harm another individual or destroy property;
- Intentionally damaging equipment or property;
- Making harassing offensive or intimidating statements, or threats of violence or retribution through phone calls, letters voicemail, email, or other forms of written, verbal or electronic communication;
- Making racial or cultural slurs or other derogatory remarks associated with, but not limited to, race, language or sexuality;
- Committing any fraudulent or illegal act such as permitting use of his/her medical ID card by others, forging or altering a prescription theft of prescription forms and/or theft of medications or other criminal acts on the clinical premises;
- Engaging in other dangerous, disruptive, antisocial actions/behaviors that threaten the safe operation of the clinic and administration and/or that threaten safety of employees and others; and
- Damaging, defacing, and/or stealing property belonging to the health center staff
- Engaging in other forms of harassment, including, but not limited to, persistent inappropriate behavior.

I have read, understand, and agree to the provisions of this Patient Conduct Agreement:

Signature of Patient or Guardian Date

Specialists in Adult Retina Care

- Macular Degeneration
- Diabetic Retinopathy
- Retinal Detachment
- Ocular Oncology
- Uveitis

Algonquin Office

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847-488-0677 (Fax)

Rockford Office

1075 Featherstone Rd,
Suite 10
Rockford, IL, 61107
815-904-6016 (Office)
815-904-6256 (Fax)

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NON-COVERED SERVICE FEES

Effective 1/1/2025

Background: Retina Health Institute has joined a movement among small practices intended to protect our way of providing care. We have instituted this Non-Covered Services Fee for all patients in the practice. These out-of-pocket per-instance fees cover the cost of administrative and care coordination services we provide that are NOT covered by your insurance. This is a hybrid approach, as we WILL continue to bill insurance as we always have for the health care services that they cover and have instituted the non-covered Services fee only for services they won't. Health plans have complex and detailed rules about what is considered a covered-service and what they will not cover. Over time, more and more of the support we provide is beyond that which is covered by insurers. Some of the services that we provide that are not covered by most insurance plans are detailed below for financial transparency for our patients:

- Yearly Prior Authorizations: **$125**
- Prescription refill request outside of appointment time: **$25**
- No show/cancellation fee if not done 24/hrs in advance: **$75-$150*** *(This does not apply to emergencies.)*
- Failure to schedule appointment prior to exit: **$25**
- Appeals after first attempt: **$50**
- Non-urgent page to doctors after hours: **$25**
- Incorrect insurance on file: **$300**
- Wrong address on file: **$25**
- Discharge processing fee: **$50**
- Excessive rescheduling fee (3+ times for a single appointment**): $100**
- Administrative paperwork fee: **$25 per page**
- Telehealth visit: **$50**

I have read, understand, and agree to the provisions of the Non-Covered Service Fees:

Patient Name: _____

Signature of Patient or Representative: _____ Date: _____