Retina Associates OF UTAH, P.C.

Diseases and Surgery of the Retina and Vitreous

Gregory S. Brinton, M.D.
Kirk E. Winward, M.D.
Robert C. Kwun, M.D.
Mano Swartz, M.D., P.C.
James G. Howard, M.D.
Victoria M. Knudsen, M.D.
Eric P. Brinton, M.D.

Salt Lake
Intermountain Medical Center
Eccles Outpatient Ctr./Bldg. 2
5169 S. Cottonwood Street
Suite 630
Salt Lake City, Utah 84107-6771
(801) 312-2020 **Phone**
(801) 312-2022 **Fax**

Layton
Robert F. Bitner Medical Building
2132 North 1700 West
Suite 130
Layton, Utah 84041
(801) 775-8222 **Phone**
(801) 775-8223 **Fax**

Provo
Utah Valley Physicians Plaza
1055 North 300 West
Suite 420
Provo, Utah 84604
(801) 357-7999 **Phone**
(801) 357-7020 **Fax**

Logan
810 South 100 West, Suite C
Logan, Utah 84321
(435) 752-1010 **Phone**
(435) 752-1011 **Fax**

Website
www.retinautah.com

LIFETIME FINANCIAL POLICY SIGNATURE FORM

REV. 10-17

Thank you for choosing us as your health care provider. We are committed to rendering the best possible medical care.

We are participating Medicare providers. We also participate and accept assignment on most other insurance plans. We are happy to submit your medical charges to your primary insurance carrier.

All patient responsible portions are due at the time of service such as Medicare's 20% copayment, any deductibles, secondary insurance portions, other copayments, etc. If you do not have insurance coverage, payment in full is due at the time of service. Interest at a rate of 1% per month (12% per year) will be added to all accounts past due.

You, as a patient, agree to authorize direct payment by insurance companies to Retina Associates of Utah, P.C. or Mano Swartz, M.D., P.C., you also authorize the release of any information acquired in the course of your examination or treatment to those insurance companies. You authorize any holder of medical or any other information about you to release to the Social Security Administration and health care financing administration or its intermediaries or carriers any information needed for this or a related Medicare claim.

If your account is turned over to a collection agency for non-payment, you agree to pay the 33% collection fee, plus any additional costs which may include attorney fees, court costs, filing fees, etc. and as per HB128, a $10.00 fee will be added.

You hereby consent to being contacted by telephone at any telephone number, including, but not limited to, wireless/cellular phone numbers, provided by you or anyone acting on your behalf to Retina Associates of Utah, P.C. or Mano Swartz, M.D., P.C., or any affiliates, including but not limited to billing companies and third-party collection agencies. The methods of contact may include pre-recorded/artificial voice messages and/or the use of an automated dialing device, and/or the use of text messages—some or all of which may result in data charges. You also consent to receiving emails to any email address provided by you or anyone acting on your behalf.

Your signature indicates you understand and agree to everything included in the above financial policy.

X_____ Date _____

Signature of Patient or Responsible Party