THE RETINA PARTNERS
2021 Santa Monica Boulevard, Suite 720-E
Santa Monica, CA. 90404
(310) 829-3303

PATIENT RESPONSIBILITY AGREEMENT

This is to inform you that your insurance carrier may not cover procedures or diagnostic tests that your doctors consider necessary for the proper treatment of your medical condition. We agree to file the claims for you and assist in any appeal process necessary.

You understand that your Provider may not charge you for a Service determined to be not medically necessary or experimental unless you specifically agree to pay for it. You also understand that your Provider and/or you may appeal any determination that a Service is not medically covered by filing a grievance or appeal described in your Benefit Agreement of Evidence of Coverage. You also may have the right to Independent Medical Review through DMHC.

Your signature on this form acknowledges that you agree to bear full financial responsibility for all services provided if:

1. The Services are not covered by your insurance carrier, or
2. The Services have not been otherwise approved for payment.

_____
Member Name

_____ _____
Member Signature Date