

## Urology Care Patient Billing Policy

Thank you for choosing Urology Care for your care. As part of our commitment to service, we make every effort to offer efficient and helpful billing services. To this end, we require you to read, understand, sign and date this policy prior to any evaluation or treatment. If you have any questions regarding this policy, please ask to speak with our billing department at (520)298-9278.

### Expectations

You can expect our office to make good-faith efforts to provide you quality urologic care. You can expect our good-faith effort to provide clear, timely account information to help you settle your accounts. We expect you to be responsible for and pay all fees not covered by your insurance and maintain your account in good standing. Should financial circumstances in these tough economic times make it difficult to satisfy your account, we expect you to contact our billing department to apply for our payment plan. In the event you are unable to maintain your account in good standing, Urology Care reserves the right to turn your account over to collections and to terminate the doctor-patient relationship. If we terminate the doctor-patient relationship we will provide you with notice and assist in transitioning you to another physician of your choosing. **Please note that even if we terminate the doctor-patient relationship, you are still responsible for the balance.**

Once your insurance determines the amount you owe, we will bill you for that amount. Payment is due upon receipt. Payments by self-pay patients are due at time of service. Thirty days after the first statement date, the balance will become overdue. We accept cash, checks, credit cards (MasterCard, Visa, or Discover only), and debit cards. Please note that we charge a 35% surcharge once your account goes to collections.

### When visiting our office

**It is essential that you provide us with your most current primary and secondary insurance cards to each visit, so that we have the most accurate and up-to-date information to submit charges to the insurance carrier on your behalf. Please note that if your insurance requires a referral or authorization for your visit, it is your responsibility to get it and bring it to your appointment. If you do not bring it to your appointment, we will be unable to keep your appointment and will have to reschedule you.**

### Outside lab services

Please note that if there is a need for an outside lab for portion of your care, you may receive a separate bill from that lab for its services. You, or your insurance, will be responsible to pay that bill.

### Medicare patients

We participate with Medicare and we accept assignment. Patients are responsible for meeting their annual deductible and paying for the 20 percent coinsurance. We will submit your medical bills to Medicare and, if necessary, to your secondary insurance carrier. Once we

receive Medicare's response we will bill you for amounts due if you owe any deductible or coinsurance. **If your secondary does not pay within 60 days, you are responsible for the coinsurance.** Payment for your portion is due upon receipt of our bill.

### **Patients with insurance**

**Please know that it is your responsibility to know: (1) your coverage eligibility, deductibles, copayments, referral and precertification requirements; and (2) whether Urology Care is a provider for your plan. We will obtain a prior authorization for procedures; however an authorization is not a guarantee of payment. If for any reason services are denied by your insurance, you will be personally and fully responsible for all charges.**

**Copayments:** Copayments are due at the time of service. Please be sure to bring payment for such fees to your appointment or your appointment may have to be rescheduled.

**Balance Due:** We will submit medical bills to your primary insurance (and secondary insurance, if necessary and if we are a provider with the plan) on your behalf. Once we receive your insurance company's response, we will bill you for any remaining payment you owe. Payment for your portion is due upon receipt of our bill.

**Self-Pay Patients:** Payment is due at time of service.

**Procedures:** All insurance deductibles will be collected prior to scheduling any procedures. Any remaining balances and non-covered charges will be the patient's responsibility.

### **Non-participating plans**

If Urology Care is not a participating provider contracted with your insurance plan, the expenses for your care will be your responsibility. When you arrive for your visit, you may speak with our billing staff about the charges.

Not all health plans are the same nor do they cover the same services and supplies. In the event your health plan determines a service or supply to be "not covered"; you will be responsible for the complete charge for that particular service. Payment is due upon receipt of our bill.

### **Fees**

**Bounced Checks:** We charge a fee of \$40 for any checks returned for insufficient funds. We also participate in the Pima County's Check Fraud Program.

**Missed Procedure Appointments:** We reserve the right to charge \$40 for any missed procedure appointments. These procedures include cystoscopies, vasectomies, prostate biopsies and botox injections. With the high demand for procedure appointments, we take every step possible to minimize each patient's wait for a procedure appointment. Failing to cancel your procedure appointment at least 24 hours in advance prevents us from reducing the wait for another patient. To avoid the \$40 charge, please notify us at least 24 hours before your scheduled appointment should you need to cancel.

**Processing Third-party Forms:** If you require our office to complete third-party forms (disability, life insurance, etc.) for your benefit, there will be an additional charge that must be paid before we process the forms.

Thank you for taking the time to read and understand this Financial Policy of Urology Care PC.

I have read, understand and agree to this financial policy of Urology Care, P.C.

X \_\_\_\_\_  
Patient signature/responsible party

X \_\_\_\_\_  
Please print patient name

Date \_\_\_\_\_