

Urologic Financial Policy / Consent to Treat

Med Rec # _____

You must pay your copay and any coinsurance at each visit. You must pay any deductible or coinsurance BEFORE any office procedure, CT or surgery is performed.

Financial Responsibility

Urologic (Clinic) participates in the Medicare and Mississippi Medicaid programs as well as other commercial insurance products. We do not participate in some HMO plans. If the Clinic participates in your insurance plan you will be responsible for all copays, deductibles, and coinsurance amounts at the time of service. You will also be responsible for any services not covered by your insurance plan. **You must bring your insurance card(s) to every visit.**

If the Clinic does not participate in your insurance, you will be considered Self Pay. You will be required to pay a \$200 deposit on your first visit which will be applied to your charges. If you have any questions regarding the networks we participate in, please ask prior to being seen.

If you do not have any insurance, you will be **required to pay a \$200 deposit** on your first visit which will be applied against your charges. **This must be paid before you are seen.** All future charges should be paid at time of service unless you work out other payment arrangements with our billing staff. We do offer patients with no insurance coverage a discount when charges are paid in full at time of service. Please ask any of our billing or check out staff about this discount.

You understand that you are financially responsible for all Clinic charges unless covered and paid by your third-party insurance as explained above. If you should default on your financial responsibility, you understand that your account may be turned over to a collection agency. If this occurs, you may be charged for all reasonable collection fees incurred by the Clinic. You consent to receive communications regarding your account from the Clinic or its collectors by any phone number(s) you provide including cell, employer, and home landline numbers.

The Clinic reserves the right to charge patients a \$25.00 fee for no-show/cancellation (less than 24 hours' notice), medical records, FMLA, etc.

Assignment of Benefits

Medicare and Medicaid: You hereby request that payment of authorized Medicare/Medicaid benefits for services rendered by the Clinic on your behalf, shall be made to the Clinic, and you specifically assign such benefits to the Clinic. You hereby certify that all information given by you in connection with applying for such benefits is correct and complete in all respects. You understand that payment for certain services not deemed medically necessary by Medicare/Medicaid are not authorized under the Medicare/Medicaid Programs to pay any and all copays, coinsurance, and deductibles upon demand by the Clinic, including at the time of service.

Commercial Insurance: You hereby assign to the Clinic all rights, benefits and interest under any insurance policy, health plan, or workers compensation plan in consideration for services rendered by the Clinic. You hereby authorize payment of such benefits directly to the Clinic for treatment you receive by the Clinic. You understand that you are required to pay any and all copays, coinsurance, and deductibles upon demand by the Clinic, including at the time of service.

DISCLAIMER: Urologic utilizes an independent lab, PathGroup, for lab services/pathology. The billing is independent of Urologic. It is your responsibility to determine whether PathGroup is in-network with your insurance.

Consent to Release Health Information for Billing and Payment Purposes

You hereby consent to the release of your health information by the Clinic for the purpose of obtaining authorization and payment of services rendered to you by the Clinic. Your consent does NOT waive your privacy rights under federal law (known as the Health Insurance Portability and Accountability Act, or HIPAA).

"I understand that payment is due at the time of service. I agree to pay collection fees of 25% of the unpaid balance at such time that my account is placed with a collection agency. I further agree that I am responsible for all costs associated with the collection of my account, including but not limited to postage costs, and all credit card processing costs. In the event my account is referred to an attorney for collection, I agree to be liable for attorney's fees of 33% of the unpaid balance, and all costs of court. I also authorize my employment location and status to be verified for the purpose of processing my bill for payment. I authorize the use of the phone number and other contact information I provide, including cellular number and any future numbers assigned to me, for calls, texts, emails, to include automated dialers, to contact me regarding my care and my account by the medical provider and this medical providers' business associates."

Patient or Responsible Party Signature

Date