

encore UROLOGY

Financial Policy

- I. All patients must complete our Information and Insurance form before seeing the doctor. Please give your insurance card(s) to the receptionist for copying. If payment is not made in full, you agree to pay all costs of collection, including attorney fees.
- II. PAYMENT IN FULL IS REQUIRED AT THE TIME OF SERVICE UNLESS A PRIOR ARRANGEMENT HAS BEEN MADE. We accept cash, check, Visa, MasterCard, Discover and American Express.
- III. Patients under the age of 18 must be accompanied by a Parent or Guardian. The Parent or Guardian is responsible for payment at the time of service. We cannot be bound by any divorce or other family relationship contract.
- IV. Any account 90 days past due will be turned over to an outside collection agency and you will be responsible for all costs of collection in addition to unpaid charges. A typical collection fee is 40% to 60% of the unpaid balance.
- V. As a member of the National Credit Bureau Network, we report to all three credit agencies, Equifax, TransUnion and Experien. Prior to accepting any method of alternative payment arrangement, a full credit report may be run in order to grant credit.
- VI. A \$75.00 charge will be charged to your account for any check returned by the bank for any reason. We will resubmit the check for payment to the bank one time, if requested. However, if funds are still insufficient, we will not accept payments by check from you in the future.

MEDICARE

We are participating providers with Medicare. Medicare typically pays 80% of approved services. You will be responsible for the prevailing Medicare deductible and full payment of any non-covered service at the time of each visit. Non-covered services include but are not limited to: complete annual physicals, immunizations and diagnostic tests done for screening purposes.

SUPPLEMENTAL INSURANCE

Your supplemental insurance may cover the 20% not paid by Medicare. Medicare submits claims directly to some supplemental insurance carriers including those connected to their Medigap/Crossover program. We will file a claim with your insurance carrier if Medicare does not forward that claim to your supplemental insurance. If your supplemental insurance carrier does not pay the physician directly, you will be required to pay the 20% not paid by Medicare.

OUT-OF-NETWORK INSURANCE

If you have out of network insurance or non-par insurance then we do not participate with your insurance company and your bill with the physician is your responsibility and is due at the time of service. We will, as a courtesy file the claim to your insurance company for you if you furnish your insurance information. Considerable care has been taken in setting our fees. We want to assure you that our charges accurately reflect the complexity of care rendered and the skill and expertise required for your care. If your insurance company refused to accept the level of our charge, you are responsible for payment in full.

IN-NETWORK INSURANCE

We currently participate with some "Managed Care" insurance programs (Community Health Partners and Pro-America). You will be required to pay any co-pay or unfulfilled deductible for non-covered service at the time of each visit. As with any other insurance policy, if your insurance carrier has not paid your account within 90 days, the balance will automatically become due from you.

MEDICAID

We are participating providers with Medicaid. If you have a Medipass provider, your service will need to be verified with that provider prior to treatment. If you are not eligible for Medicaid benefits at the time of service, payment in full will be required. If payment is not made in full, I agree to pay all costs of collection, collections fees and court costs, including attorney fees. I authorize Encore Urology to furnish information to all insurance carriers concerning my illness and treatment and I hereby assign Encore Urology all payment for medical services rendered to me (the patient) or my dependents, in the event an insurance claim is filed by the practice. I further agree that a photocopy of this agreement shall be valid as the original.

RESPONSIBILITY FOR CHARGES

"I understand that if my insurance company denies the claim for any reason, I will promptly pay all outstanding charges. I am also fully responsible for all charges incurred if I have given incorrect insurance information or if I fail to notify Encore Urology of any changes in my insurance coverage."

RELEASE OF INFORMATION

"I authorize the release of any medical information necessary to process insurance claims associated with treatment at Encore Urology For Medicare Part-B, I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers, or the billing agent for Encore Urology any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of insurance benefits either to myself or to the party who accepts the assignment."

PRIVACY NOTICE

"I have had the opportunity to review the Notice of Privacy Practices, and I understand that I may ask questions about the Notice of Privacy Practices at any time. The receptionist will provide a copy of the Notice of Privacy Practices upon my request."

AGREEMENT TO PAY FOR SERVICES

"I agree to pay Encore Urology for all charges for services received today, and during future visits. I understand that payment in full, insurance co-payment or insurance co-insurance is required at the time that services are rendered. I am providing my credit card which I understand may be charged to pay for overdue balances. I further understand that if this account is referred to an agency, court or attorney for resolution, I will be responsible for all fees associated with collection. I also understand that if I become a patient on a payment plan who fails to complete payment plan as agreed, I will owe the balance of Encore Urology standard fees and not the balance of the discounted or fee arrangement. I also have read and agree to comply with the Encore Urology financial policy."

ASSIGNMENT OF BENEFITS

"I authorize assignment of all medical insurance benefits to the named provider for medical services received."

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay a fixed allowance for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance/co-pay, any other balance not paid for by your insurance company. It is also your responsibility to provide us with current and active insurance information.

My Method of Payment: Cash Check Credit Card

If you have any questions about our financial policy, please feel free to ask our billing department for clarification.

I HAVE READ AND UNDERSTAND MY FINANCIAL RESPONSIBILITIES.

Patient Signature: _____ **Date:** _____