



Financial Policy

Thank you for choosing Cleveland Urologic Surgery, PA as your urology provider. We are committed to providing you with quality health care. We have developed this payment policy to help answer questions you may have regarding the patient and insurance responsibility for services rendered. Please read it, ask us any questions you may have, sign in the space provided and return to us. A copy will be provided to you upon request.

1. **Insurance:** We participate with most insurance plans, including Medicare. If you are not insured by a plan we participate with, payment in full is expected at each visit. If you are insured by a plan we participate with, but you don't supply us with an up to date insurance card, payment in full for each visit is required until we are supplied with the necessary information to file the claims. This includes a referral from your primary care physician if required by your insurance company. Prior authorization is often needed from insurance companies for testing and other procedures. We will be happy to assist in getting these procedures authorized, but since we participate with so many different carriers who have different guidelines; it is impossible for us to keep up with the requirements for every insurance company. Knowing your insurance benefits and requirements is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. **Co-payments and Deductibles:** All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients may be considered fraud. Please help us in upholding the law by paying your co-payment at each visit. We accept Checks, Cash, MC/Visa, American Express and Discover. If the co-pay is not paid by check-out on the day your services are rendered, a late fee of \$10.00 will be added to your account.

3. **Proof of Insurance:** All patients must complete our patient registration form before seeing the doctor. You must provide us with a copy of your current insurance. We may also ask you to provide us your driver's license or other photo ID. If supplied photo ID does not show your current address, you may be asked to supply a utility bill or other correspondence showing current residence. If patient is a minor, parent or guardian will be required to supply requested information.

4. **Claims Submission:** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your

insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract. If a claim is not paid within 60 days, due to failure to respond to the insurance request, the balance will be billed to you directly.

5. Coverage Changes: If your insurance changes, please notify us at your next visit so we may make the appropriate changes to help you receive your maximum benefits. If you do not provide us with these changes, the balance will automatically be billed to you.

6. Nonpayment: Our collection department will make attempts to contact you by phone and by mail regarding your delinquent account. In limited circumstances we will make payment arrangements. If payment arrangements are made, but not kept, then all prior arrangements become null and void. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency. In the event of finding it necessary to turn your unpaid balance over to a collection agency, all collection fees and/or legal fees will be owed in addition to the remaining balance and become the patient's responsibility. We will add a \$10.00 late fee each time we have to send a statement for uninsured or after notification from insurance company of patient's responsibility.

7. Missed Appointments: Please try to give our office 24 hours notice of cancellation so that we may offer that appointment to another patient. Patients with a history of no-shows may be discharged from our practice.

8. Returned Checks: We charge a \$25.00 processing fee for returned checks. Patients who have written more than one returned check will be required to pay by cash.

9. Forms: There is a form completion charge of \$10.00 per form.

Our practice is committed to providing the best treatment to our patients. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy of Cleveland Urologic Surgery, PA, and agree by its guidelines.

_____ Patient's Name (Printed)	_____ Patient's Date of Birth
_____ Signature of Patient or Responsible Party	_____ Date
_____ Witness Signature	_____ Date