Urology Professional Association Financial Policy

Med Rec #________________

You must pay your copay and any co-insurance at each visit.

Financial Responsibility

Urology Professional Association (Clinic) participates in the Medicare and Mississippi Medicaid programs as well as other commercial insurance products. 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, we will file your insurance as a courtesy but you will be responsible for all charges not paid by your insurance. You will be required to pay a $200 deposit on your first visit which will be applied against your charges.

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 that occurs, you may be charged for all reasonable collection fees incurred by the Clinic.

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 Program and that you may be responsible for these charges. You also understand that you are required by 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.

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).

____ ______________________

Patient or Responsible Party Signature Date