



PEDIATRIC UROLOGY

Associates, P.C.

OUR FINANCIAL POLICY

Pediatric Urology Associates (PUA) is committed to providing you with the best possible care and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees or your financial responsibility.

Patients must complete all Information Forms prior to seeing the physician.

A copy of your insurance card(s) will be made for your file

Co-Payments/Deductibles – By law, we must collect your carrier designated copay and/or deductible at the time of service. Please be prepared to pay your copay/deductible at each visit. In the case of surgery, if your plan requires a deductible, it must be paid prior to the surgery date.

Non Copay Plans – If your plan does not require a copay and we participate, we will accept the designated fee. You are responsible for any deductible and balance your plan indicates on their explanation of benefits, including the full balance charged if insurance carrier deems you responsible due to termination of coverage

Referrals – If your plan requires a referral from your primary care physician it is YOUR responsibility to obtain it prior to the visit and have it with you on the day of service. If you do not have a valid referral with you or on file, you will be required to **RESCHEDULE YOUR APPOINTMENT**

Usual and Customary (UCR) – Is a term developed by the insurance carrier industry to reflect “average charges” from specific physicians in designated geographic localities. The usual and customary amount noted on the explanation of benefits (EOB) does not accurately reflect individual charges. Therefore, the usual and customary charges does NOT supercede our fees except as defined for “Out of Network Insurances”

Participating Insurances – You are responsible for all copay, coinsurance and deductible payments as required by your participating insurance plans. We will accept the insurance carrier’s rate as payment in full after your financial responsibilities have been met. Our full fee will be due by the patient if the insurance carrier indicates termination of coverage for a specific date of service

Out of Network Insurances (Office Visits) - You are responsible for 100% of the charge and payment for any services rendered on the day of service. If an unanticipated test/exam is performed during the visit, we will allow 45 days for payment for the test/exam only. You will be responsible for payment of 100% of the of the charge amount

Out of Network Insurances (Surgery) – You are responsible for paying your out of network deductible, if applicable prior to your scheduled surgery date. Once a claim is processed, you will remit the payment from the carrier and PUA will require an additional 5% payment, from you, based on the “allowed amount”. If payment is not received within 45 days from the date of service, you will be responsible for 100% of the charges as billed on your PUA statement

Self Pay Patients (No Insurance) –You are responsible for payment rendered on the day of service.

Account Balances – You are responsible for timely payment of your account. Pediatric Urology Associates reserves the right to reschedule or deny a future appointment on delinquent accounts

I acknowledge that if the provider is not paid in full at the time of service or submits a claim to my insurance company, the provider is extending and otherwise deferring my time to pay the full charge for services rendered until the claim is paid by me or paid or denied by my insurance company. I further acknowledge that in the event my account remains past due and is referred to outside collection, such as a collection agency/law firm, I agree, to authorize said entities to communicate with my insurance company regarding my past due account and further authorize said entities to obtain and review my credit report

WE ACCEPT CASH, CHECKS, MASTERCARD, VISA, DISCOVER AND AMERICAN EXPRESS

THANK YOU for taking the time to review our policies. Please feel free to ask questions or share with us any specific concerns.

(Responsible Party Signature)

(Date)