PRACTICE PAYMENT POLICY

OCONEE UROLOGY PC
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We are committed to providing you with the best possible care. In order to achieve these goals, we need your assistance and your understanding of our payment policy. If you have any questions about the policy, please discuss them with our Practice Manager.

FOR PATIENTS WITH INSURANCE: We bill most insurance carriers for you if proper paperwork is provided to us. Your insurance coverage is an agreement between you and your insurer. It is your responsibility to remit payment for charges not covered by your claim and insure your carrier remits payment.

PPO PLANS: We have made prior arrangements with many insurers and health plans to accept assignment of benefits. We will bill those plans for which we have an agreement. We will require you to pay the authorized *deductible and co-payment at the time of service*. In the event you provide inaccurate information or if your health plan determines a service to be "not covered", you will be responsible for the complete charge.

Non-Contracted Insurance Plans: You are responsible for full payment of charges at the time of the visit if we do not have a participation agreement with your insurance carrier. If you provide our office with the necessary billing information for the visit, we will submit the charge on your behalf to your carrier for reimbursement to you.

Medicare: As a participating provider, we will bill your Medicare carrier. *You are responsible for your 20% co-payment. It must be collected it at each and every visit or prior to any scheduled elective surgery.*

Medicaid: You will need to provide our office with your *Medicaid ID Card* prior to your visit along with a letter or *authorization number from your referring physician.* We will require you to pay the authorized *co-payment at the time of service.*

Secondary Insurers: Having more that one insurer DOES NOT necessarily mean that your service is covered 100%. Secondary insurers will pay as a function of what your primary carrier pays. We will bill your secondary carrier as a courtesy. We don't bill third insurance carrier. *You are responsible for any balances after your insurance(s) has cleared.*

Self-Pay: If you are uninsured, you are responsible for *payment in full at the time of service*, unless prior arrangements have been made with our Billing Department. *A deposit of $100 is required upon signing in.*

Divorce Decrees: This office is NOT a party to your divorce decree. Adult patients are responsible for their bill at the time of service. The responsibility for minors rests with the accompanying adult.

Minor Patients: The adult accompanying a minor on the initial visit will be responsible for full payment or insurance co-payments. For unaccompanied minors on the initial visit, non-emergency treatment will be denied.

Responsible Party Initials required here: _____

Missed Appointment: In order to provide the best possible service and availability to all our patients, it is our policy to charge a fee of $20 for any appointment not canceled at least 24 hours prior to the scheduled appointment.

Telephone Prescription refills: There will be a $5 administrative charge for all telephone prescription refills. Patients will be responsible for the charge.

Medical Procedures and Outpatient Surgery: It is the patient responsibility to pay any deductible, co-insurance, or any portion of the charges as specified by their plan. Estimated down payment of 20% must be paid before any elective surgery.

Collections: Any outstanding balances are due within 60 days of the statement. If you experience circumstances out of your control, please call our office and we will be happy to make payment arrangements. All balances that reach 90 days past due will be sent to a collection agency and 30% charge will be added to the patient balance. At the same time, patient will be discharged from our practice.

Payment for Services Performed: Payment for service is due in full at the time service is provided in our office. For your convenience we accept Cash, Check, VISA and MasterCard.

There will be $20 charge for returned checks.

Unless specifically stated herein to the contrary, Patient or Patient's Guardian expressly grants permission to Oconee Urology, P.C. to leave messages with any person who should answer the contact numbers provided herein or on any answering machine, which may be activated on said numbers for the purpose of appointment reminders or for request for the Patient to call this facility.

Medical Records Fax Transmission Authorization: *I understand that Oconee Urology, P.C. will be transmitting my medical records electronically and I authorize them to do so. If they are received by another party in error, I absolve Dr. Stewart and Dr. Velimirovich of any and all liability relating to such transmission of said records.*

Authorization of Treatment/ Assignment of Benefits/ Release of Information: *I have read and understand the financial policy of the practice and I agree to be bound by its terms and conditions. I also understand and agree that such terms may be amended from time-to-time by the practice.*

Patient Name: _____

Date of Birth: _____

Signature of Patient/Guardian: _____

Date: _____