Advanced Urogynecologic Care

FINANCIAL POLICY

The Advanced Urogynecology Center group believes that part of a good healthcare practice is to establish and communicate our financial policy with all our patients up front. Please read the following and sign the bottom to indicate your acceptance and understanding of the following terms:

1. **PAYMENT** is expected at the time of your visit. We accept cash, check or credit card (Visa, Mastercard or Discover, NOT American Express). Payment will include any unmet deductible, co-insurance, or non-covered charges from your insurance company. If you do not carry insurance, payment is expected in full at the time of your visit, prior to being seen.

2. **INSURANCE:** We are participating providers with several insurance plans and we will file all of these insurance claims. Please remember that insurance is a contract between the patient and the insurance company and ultimately the patient is responsible for payment in full. If your insurance company does not pay the practice within a reasonable period of time, you will be billed. If we later receive payment from your insurer, we will refund any overpayment to you.

   If our doctors are not listed in your plan's network, you may be responsible for partial or full payment. Due to the many different insurance products out there, our staff cannot guarantee your eligibility and coverage, therefore, it is the patient's responsibility to call and verify network status prior to appointments. Many websites have erroneous information and are not a guarantee of coverage. You are responsible for obtaining a properly dated referral if required by your insurer and responsible for payment if your claim rejects for the lack of one.

   Not all insurance plans cover all services. In the event your insurance plan determines a service to be "not covered," you will be responsible for the complete charge. Payment is due upon the receipt of statement from our office. All procedures billed in this office are considered covered unless limited by your specific insurance policy. Delay in these payments from the patient could result in being submitted to collections.

3. **RETURNED CHECKS** will incur a $50.00 service charge. You will be asked to bring cash or credit card to cover the amount of the check plus the $50 service charge to pay the balance **prior** to receiving additional services from our staff.

4. **ACCOUNTING PRINCIPALS:** Payment and credits are applied to the oldest charges first, except for insurance payments which are applied to the corresponding dates of service.

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5. **FORM FEES:** Copying medical records requires staff time and time away from patient care for our doctors. We require payment for release and/or copies of medical records as well as FMLA paperwork. The following indicates the fee schedule:

   Medical Records Charge- Flat $25.00

   Please allow 10 business days for all paperwork to be processed and ready for pick up.

6. **BILLING OFFICE**: If you have questions with respect to any of your billing statements, our biller is available to assist you Monday-Friday at 224-251-7387, option #3.

7. **CANCELLATIONS OR MISSED APPOINTMENTS**: If you do not cancel your appointment at least 24 hours prior, or if you no-show, you will be subjected to a $50 fee with the exception of procedures such as, but not limited to urodynamics testing which is subject to a fee of $100.

I HAVE READ AND UNDERSTAND THE PRACTICE'S FINANCIAL POLICY AND AGREE TO BE BOUND BY ITS TERMS AND CONDITIONS. I UNDERSTAND THAT I, PERSONALLY, AM FINANCIALLY RESPONSIBLE TO THE ADVANCED UROGYNECOLOGY CENTER FOR CHARGES NOT COVERED BY MY INSURANCE CARRIER. I UNDERSTAND THAT I MAY NOT BE ALLOWED FUTURE APPOINTMENTS DUE TO MY ACCOUNT BALANCE DETERMINED BY THE TEAM AT THE ADVANCED UROGYNECOLOGY CENTER. I ALSO UNDERSTAND AND AGREE THAT SUCH TERMS MAY BE AMENDED BY THE PRACTICE FROM TIME TO TIME.

_____ _____

Signature of Patient (of guarantor, if applicable) Date

_____

Printed Name of Patient

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CREDIT CARD ON FILE AGREEMENT

PATIENT NAME _____

DOB_____

CARD TYPE (CIRCLE ONE) VISA MASTERCARD DISCOVER

CARD # _____

EXPIRATION DATE _____/_____ SECURITY CODE _____

I have read and agree with the billing rights information below:

I hereby authorize Advanced Urogynecology Center to charge my credit card on file for the amounts due for services rendered after insurance resulting in the patient responsible balance. The patient responsibility amounts as determined by my insurance company and as reflected on the explanations of benefits (EOB's) the insurance company sends to me. Any overpayments on my account will be refunded to the responsible party. This designates as my signature on file and therefore it is not required, I sign paper receipts each time. This authorization is to remain in effect until The Urogynecology Center receives a written notification from me of its termination. If my bank account or credit card information changes for any reason, I will notify AUC immediately. I understand it is my responsibility to keep AUC informed of any changes and to keep my account in good standing.

If you think your charges are incorrect, please provide your name, account number, telephone number, and a brief written explanation of the problem. We will make any necessary adjustments to your account within 30 days of payment. After 60 days, all charges will be assumed to be correct and final. In the event of a declined charge, your account will be charged a $25.00 service fee for each occurrence.

AUTHORIZED SIGNATURE _____ DATE_____

WITNESS SIGNATURE _____ DATE _____

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ACCOUNT PAYMENT AGREEMENT

I understand that by choosing to not provide a credit card to have on file I agree to pay my account balance **IN FULL at EVERY appointment** regardless of if I have received a statement to my home address yet. A statement is available to me by asking the front desk the day of payment to keep for my personal records in addition to a receipt. I understand I cannot ask to delay the payment of my account because I have not received written notice in the mail. I understand no further treatment may be provided to me until my balance is paid in full.

AUTHORIZED SIGNATURE _____ DATE_____

WITNESS SIGNATURE _____ DATE _____

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