3841 Piper Street Suite T300 Anchorage, AK 99508

PH (907)563-3103 FAX (907) 561-1862

FINANCIAL POLICY

Thank you for choosing Alpine Urology. We are committed to providing you the best urological healthcare available. You are required to read and sign our financial policy prior to any treatment. Please feel free to ask any questions and a copy of this policy will be provided to you upon request. As a courtesy to our patients, we bill all insurance types.

INSURANCE... We are participating providers for Medicare, Medicaid, Blue Cross/Blue Shield, Aetna, and Cigna. It is **your responsibility** to know your insurance benefits. If you are unsure of your benefits, please contact your insurance carrier with questions. All patients with insurance coverage of any type must show their insurance card for us to bill your insurance. If you do not provide proof of insurance, you will be expected to **pay in full** at the time of service and will be considered a self-pay patient until the appropriate billing information is provided to our office. If you are not insured, **payment in full** is expected at the time service is rendered.

COPAYMENTS/COINSURANCE/DEDUCTIBLES... All patient responsibility for services must be paid at the time of service. This is part of your contractual obligation with your insurance company.

NON-COVERED SERVICES... Please be aware that some or all of the services provided may not be covered or not considered reasonable or necessary by some insurers. It is your responsibility to pay in full for these services at the time of your visit.

USUAL & CUSTOMARY... Our prices are representative of the usual and customary charges for our geographic area. You are expected to pay in full for any balance after insurance. At our discretion, Alpine Urology may assist you in appealing your insurance determination and/or appeal benefits on your behalf.

PROOF OF INSURANCE... All patients must complete our patient information forms and sign where indicated before seeing the doctor. We must obtain a copy of your insurance card(s) and a copy of your driver's license for billing. Failure to provide us with correct information will result in you being responsible for the balance of your claim.

CLAIMS SUBMISSION... As a courtesy to our patients, we will submit claims and assist you in a reasonable way to get your claims paid. Your insurance company may need you to supply certain

information directly to them. It is **your responsibility** to comply with their request. Please understand and be aware that the balance of your unpaid claim(s) is your responsibility.

COVERAGE CHANGES... If your insurance changes, please notify us as soon as possible so we can make the appropriate changes to help you receive your maximum benefits. **If your insurance does not pay your claim in one-hundred-twenty (120) days**, the balance will be billed to you.

NON-PAYMENT... If your account is thirty (30) days past due, you will be contacted by our billing department asking for payment in full. We will also charge three percent (3%) interest to all accounts over thirty (30) days until payment in full is collected. Partial payments will not be accepted unless your physician approves a payment plan. Our Payment Plan is a period of six (6) months for payment in full (your balance due divided by six monthly payments), with a minimum monthly payment of fifty ($50) dollars. If your balance is unpaid in six (6) months, we will refer your account to our collection agency and you may be discharged from this practice. Should this occur, you will be notified by certified mail that you have thirty (30) days to find another urologist for your medical care. During that thirty day period, our physician will only treat you on an emergency basis.

PAYMENT OPTIONS... We accept Cash, Check, Money Order, Visa, Mastercard, and Discover. Please note there will be a $30 charge for checks returned for non-sufficient funds.

MISSED APPOINTMENTS... It is our policy to reserve the right to charge for missed appointments not cancelled within twenty-four (24) hours of your scheduled appointment. Please assist us by keeping your appointment or cancel within twenty-four (24) hours. We reserve the right to discharge patients from our practice for chronic missed appointments.

Our practice is committed to providing the best urological care to our patients. Thank you again for choosing Alpine Urology. Please let us know if you have any questions or concerns.

I have read and understand the Alpine Urology payment policy and agree to adhere to its guidelines.

Patient Name:____ Date:________________________

Signature: ____

Name: (if different than patient)_______________________________ DOB: _______________________