ALASKA UROLOGY

Providence Medical Park / 3841 Piper Street, Suite T300 / Anchorage, AK 99508

Alaska Regional Campus / 2925 DeBarr Road, Suite 250 / Anchorage, AK 99508

www.alaskaurology.com

FINANCIAL POLICY

Thank you for choosing Alaska 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, MultiPlan/BeechStreet 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, Alaska 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 being seen. We must obtain a copy of your insurance card(s) and a copy of a photo ID 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.

----------PLEASE SEE REVERSE SIDE----------

SURGERIES… All patient responsibility for surgeries must be paid in advance.

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**, the balance may be billed to you.

NON-PAYMENT… If your account is thirty (30) days past due, you may be contacted by our billing department asking for payment in full. If your balance is unpaid after six (6) months, we may refer your account to our collection agency and you may be discharged from this practice.

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 with at minimum one (1) business day's notice of your scheduled appointment. Please assist us by keeping your appointment or cancelling with a minimum of one (1) business days notice. Appointments cancelled with less than one (1) business days notice will be considered a no-show. After one no-show, you will be required to pay a $25 deposit to schedule another appointment. If cancellation is not given in a minimum of (1) business day for the appointment, your $25 deposit will be forfeited and if you wish to reschedule, you will be asked for another $25 deposit. We reserve the right to discharge patients from our practice for chronic missed appointments.

PATIENT CONSENT/ASSIGNMENT… I hereby authorize Alaska Urology to release any information acquired in the course of my treatment to/from my insurance company, physician's office, hospital or any other treatment facility. I agree to be fully responsible for all expenses incurred for medical treatment. I assign to Alaska Urology any and all insurance benefits due to me, the full financial obligations for medical treatment that I have not paid for.

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

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

I also hereby acknowledge that I have received Alaska Urology's Notice of Privacy Practices.

Patient Name: _____ DOB: _____

Date: _____

Signature: _____

Name: (if different than patient) _____ DOB: _____