Northeast Georgia Urological Associates

FINANCIAL POLICY

Our office is committed to providing each of our patient's high quality health care. It is important that you understand your financial responsibility associated with our services. By informing you of our expectations, we hope to alleviate any misunderstanding concerning your financial responsibility. Please do not hesitate to contact our billing office with any questions or concerns.

Insurance Claims and Payment

- Your Insurance is a contact between you, the insurance company and/or your employer. ***Payment for our health care services is ultimately your responsibility.*** It is therefore important that you verify provider participation and benefits with your insurance company prior to your visit.
- ***Your insurance card must be presented for verification at each visit.***
- ***If you do not notify us of an insurance change, you are fully responsible for any amount not paid by your insurance company.***

Co-pays/Co-Insurance/Non-Covered Services

- We are contractually obligated by your insurance company to collect your copay at the time of service. ***Failure to pay your copay at the time of service will result in a billing fee of $25.00, which will be added to your bill on the day of the service.*** This fee will not be billed to your insurance carrier.
- Payment is due at the time of service for any amounts known to be not covered, or not paid, by your insurance plan.

Billing & Collections

- You should receive a statement approximately every thirty (30) days unless the charges are pending with your insurance company or your balance is less than $5.00. If your balance is less than $5.00 you will **not** receive a statement. ***Failure to receive a statement does not relieve you of your financial obligation. It is your responsibility to notify us of any changes in your billing information.***
- Any amount due remaining after your insurance has paid, or denied is expected to be paid upon receipt of your statement unless other financial arrangements have been made with our Billing Office.
- ***Past due accounts are subject to our collections process***. We realize that difficulties may affect timely payment of your account. If such difficulties exist, please contact our Billing Department.
- ***A $40.00 charge will be billed for all returned checks***.
- We accept cash, checks, money orders, Master Card and Visa.
- Patients being seen for Worker's Compensation claims will only be seen after confirmation has been received in our office from the Employer and/or Insurance Company. If the claims are subsequently denied you will be immediately responsible for all charges incurred related to the reported injury.
- **Georgia law** requires that a parent or guardian (with written permission of the parent) authorize treatment for a minor (under age 18). It is that adult's responsibility to ensure payment at the time of service if the minor is not covered by a verifiable insurance plan

Initial Here _____

- **Divorce:** In case of divorce or separation, the party responsible for the account prior to the divorce/separation remains responsible for the account. After a divorce/ separation the parent authorizing treatment for a child will be the parent responsible for those charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.
- ***Your signature*** below is your **consent for treatment** by Northeast Georgia Urological Associates, P.C. and **authorizes release of any information** acquired during your evaluation or treatment as may be necessary for the processing of health care claims, and to any referring physician or referring facility for the purpose of your medical care or reimbursement. ***Your signature*** also **authorized Northeast Georgia Urological Associates, P.C. to obtain medical records** from any other physician or facility necessary during the course of treatment.

HIPAA

- Covering HIPPA laws, I hereby authorize Northeast Georgia Urological Associates, P.C. to release any information contained in my chart to the person or persons listed below:

_____	_____
Name	Relationship
_____	_____
Name	Relationship
_____	_____
Name	Relationship

This is to certify that I have read and have received a copy of the Financial Policy for Northeast Georgia Urological Associates, P.C. A photocopy of this form is considered to be as valid as the original. **By signing and dating below, you are agreeing to all of the above statements**. Thank you. We look forward to working with you to achieve your healthcare goals.

This day _____ of _____

_____	_____
Print Patient's Name	Patient or Responsible Party Signature
_____	_____
Date	Witness

Initial Here _____