MidLantic UROLOGY

Financial Policy

MidLantic Urology of PA, LLC (MU) is dedicated to providing quality patient care and is also aware that financial concerns are important too.

Before your visit, MU is required to verify your member eligibility with your insurance company. In addition, when you arrive for your appointment, for your protection and in accordance with federal regulations, MU is required to verify your identity (valid driver's license or other form of acceptable photo identification). If you are unable to provide an acceptable form of identification, this may cause denial of services. Please inform the front office staff if you have any concerns regarding your insurance benefits or if you do not have insurance coverage (self-pay). If you are self-pay, and are unable to satisfy your financial obligations to MU, you may want to contact your local health department to see if you are eligible for Medical Assistance. Please feel free to contact your MidLantic Urology doctor's office to discuss your payment options in advance of your scheduled appointment.

We recommend that you contact your insurance carrier for specific questions related to your Explanation of Benefits.

Note: Please be advised that we have a separate policy for self-pay patients with no insurance coverage. Please read the following carefully and sign below.

COPAYS, COINSURANCE, DEDUCTIBLES AND OUTSTANDING BALANCES: Copays, coinsurance, deductibles, and outstanding balances not covered by insurance are due prior or at the time services are rendered. Payment can be made by check, cash, MasterCard, VISA, American Express and Discover. Additionally, you may be eligible to finance amounts which you owe for services rendered through a third-party financial institution. Inability to pay at the time of service may result in having to reschedule your appointment.

REFERRALS: It is your responsibility to obtain a referral from your primary care physician. Referrals must be presented at the time services are rendered, if applicable. If you need to have a referral faxed to us, our office will provide you with our fax number. If your insurance plan requires you to have a referral or other authorization, and you fail to provide that to us, your appointment may be rescheduled or your claim for that date of service will be processed via opt-out benefits, if applicable.

FINANCIAL RESPONSIBILITY: For those insurance companies with which we are contracted (where we are considered a participating provider), we will submit a claim on your behalf for the services we provide. Any copays, coinsurance, deductibles, and outstanding balances must be paid in full prior to or at the time of service.

ACCOUNT BALANCES: Our office provides you with monthly statements of all account activity including our charges, payments, and contractual adjustments from your insurance carrier along with payments made by you. We will charge you a returned check fee as provide by Pennsylvania law if any payments that you make to us are returned due to insufficient funds or a stopped payment.

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Please note that failure to pay outstanding balances that are your responsibility may result in (a) rescheduling of a future appointment (b) forwarding of your account to a collection agency or collection attorney of our choice, which may result in additional fees to you including attorney's fee equal to 30% of your outstanding balance, (c) reporting you to one or more third-party credit reporting agencies, and (d) termination from the practice.

MEDICARE PATIENTS:
THE FOLLOWING PROVISION APPLIES TO ALL PATIENTS WHO ARE COVERED

1) **BY MEDICARE AND HAVE SECONDARY COVERAGE, OR 2) IF YOU ARE COVERED BY A MEDICARE ADVANTAGE PLAN.**

By my signature below, I hereby authorize and request my insurance company to make payment directly to MidLantic Urology of PA, LLC for any benefits that may be due for covered services and supplies rendered to me by MidLantic Urology of PA, LLC.

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I understand that the signing of this waiver does not negate my right to request further appeal under 42 CFR 422.600.

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I certify that all information given is true.   I understand that services rendered to me will be billed to the named Insurance Carrier. If the claim submitted is rejected, I will be responsible to pay the bill.

It is understood that any dispute as to unnecessary medical services, unauthorized, or improperly, negligently or incompletely rendered medical services or medical malpractice will be determined by submission to arbitration as provided by Pennsylvania Law and not by a lawsuit or court process except as Pennsylvania Law provides for judicial review of arbitration proceedings. Montgomery County jurisdiction is agreed and accepted in all filings and proceedings.

I authorize and direct MidLantic Urology of Pennsylvania, LLC or it's designee to insurance carriers, authorized agencies of such insurance carriers or others who are financially liable for services and or medical care, all medical records and other information needed to substantiate payment for such. My initials indicate that I have read and understood the above.

Name: ____________________________________
Date of Birth: ______________________________
Date: _____________
Initials: ___________