COASTAL UROLOGY ASSOCIATES, PA
FINANCIAL RESPONSIBILITY

Coastal Urology Associates would like to welcome you as our patient. We will make every effort to work with you and your insurance carrier to maximize your health care benefits. It is your responsibility to provide us accurate and current insurance information at the time of each of your appointments or services. Please bring your current insurance information with you to each of your services. We regard your complete understanding of your financial obligation an essential element of your care.

APPOINTMENTS: Our offices automated system will call ahead of time to remind you of your scheduled appointment. It is the patient's responsibility to remember their appointment and to supply our practice with 24 hours' notice if you must cancel your appointment. **Our office will charge a $50.00 missed appointment fee for each missed appointment.**

COPAYS: **All copays are due at the time of service.** This is a contractual agreement between you, your insurance, and our practice. **If you do not have your copayment, your appointment will be rescheduled**. Please contact your insurance for your benefit allowances. Copays may be higher for specialty services.

DEDUCTIBLES: Deductibles may or may not apply to our services so it is important that you verify your benefits before services are rendered. **Based on your insurance benefits, you may be responsible for the cost of the services performed based on the amount of your deductible at the time services are rendered.** In these instances, we will request payment or a secured credit card at the time of your appointment**.** Please contact our business office prior to your appointment if you have any questions after you have verified your deductible with your carrier.

PAYMENT PLAN: Patients with a high deductible plan and/or high account balances may qualify for a short term payment plan. You may be required to have an active credit card on file. Please contact our billing office to discuss.

INSURANCE: Patients arriving for their appointment without their insurance cards will be asked to reschedule or remit payment in full. If you are asked to pay in full and insurance information is later obtained and covered, a refund will be issued to you.

INSURANCE CLAIMS: You will be responsible for any charges that your insurance doesn't cover within 45 days of submission. It is your responsibility to follow up with any unpaid service claims and balances. If your insurance does not cover a particular service based on your benefit plan, you will be required to pay the full amount. We can bill primary insurance and a secondary insurance. We do not file third insurance plans.

PAST DUE AND/OR COLLECTIONS: **A service fee of 1.5% per month or 18% per annum will be applied to your balance if the balance is not paid in full within 90 days from the date the first statement is issued.** If your account becomes delinquent or if our attempt to secure the balance or payment fails, the account will be reviewed for placement with a collection agency. **If your account is forwarded to an outside collection agency, there will be an added fee of $30.00 added to the account balance.** Monthly statements are issued to all patients with an account balance and payment is due upon receiving the statement. Patients are responsible for all related court fees associated with filing.

REFERRALS/AUTHORIZATIONS: Your insurance may require you to obtain a referral or authorization from your primary care physician before you seek services with a specialist. The patient is responsible for contacting the primary care physician to obtain the referral. Our practice is not permitted to see patients without a valid referral per our contractual agreement with carriers. You will be responsible for all denied charges if seen without a valid referral.

PRIOR AUTHORIZATIONS FOR PROCEDURES OR DRUGS: We make every effort to ensure that you receive the safest, most effective and reasonably priced prescription drugs, treatments, laboratory tests and imaging studies we feel is best suited for your healthcare. We must also abide by regulations set by your insurance companies and government agencies. **Due to the time involved, there will be a fee of $10 per authorization.** Prior authorizations required as a result of telephone requests from patients will also be charged the $10 fee.

RETURNED CHECKS: **There is a $30.00 service fee for any returned check**. The balance due and the service fee will be required to be paid by the patient in forms of a credit/debit card, money order, certified check or cash payment. A personal check for this returned check will not be accepted.

SELF PAY PATIENTS: Patients who do not have an active insurance plan will be required to a pay for services at the time of the service. If you provide us insurance information after the service date, but before the timely filing limitations of that insurance, we will file the claim and reimburse you.

MEDICAL RECORDS REQUEST: Our office will provide you or another entity on your behalf a copy of your medical records. You will be required to complete a release of information which can be obtained through our practice or you can visit our website at www.coastalurologynj.net. **Medical records requested will cost the patient $1.00 per page plus our processing fee of $10.00.**

DISABILITY / FMLA FORMS: There will be a one-time processing fee in the amount of **$25.00 for the completion of all disability or FMLA paperwork per form**. The processing fee will be due the day you present the forms which includes forms sent via fax submittal. Any special instructions need to be attached to this form.

FINANCIAL ASSISTANCE: Our practice cannot offer financial assistance to patients with active insurance plans. This is due to a contractual agreement we have with your carrier that states patients will be responsible for paying coinsurances, deductibles and copays as set forth in your policy benefit plans.

I, the undersigned, hereby agree that I have read and understand each of the above financial policies stated. If I have financial questions or concerns, I will contact the billing office to discuss them. I agree to be financially responsible for any balance due related to services rendered by Coastal Urology Associates or its partners.

Please visit our website at to review this policy and other important forms.

______________________________ Patient Name (please print)

______________________________ Patient/Responsible Party Signature

______________________________ Date