Adult & Pediatric UROLOGY of HUNTERDON

James Choi, MD

FINANCIAL CONTRACT

ADULT & PEDIATRIC UROLOGY OF HUNTERDON (APUH) appreciates the confidence you have shown in choosing us to provide your urological care. In order to provide the highest level of urological care to our patients, all of our patients are required to adhere to the financial contract of our office, which is outlined below.

PAYMENT

It is a policy of our office that your co-payment, deductible, co-insurance and/or outstanding balance is collected at the time of service.

MEDICAL INSURANCE

Our office participates with most insurance plans, including Medicare. If you are not insured by a plan with which we are contracted, payment in full is required at each visit. Please inquire with our office or your insurance company to confirm our office's participation with your plan. In the case that your insurance company does not reimburse our office in a timely manner, you will receive a bill. Medical Insurance Coverage is an arrangement between the insurance carrier and you, the patient. Please understand that it is your responsibility to know your insurance coverage and you are financially responsible for the services provided by our office.

Our office requires a copy of your insurance card as well as photo identification, and our completed, signed Patient Registration forms. Verification of benefits is NOT a guarantee of payment. Please remember that any changes made to your insurance policy may affect coverage and reimbursement rates. You will be financially responsible for services not covered by your insurance carrier within a 30 day period of determination. *We accept Cash, Checks, Discover, Visa and Mastercard for your convenience.*

Deductibles, Co-insurance and Co-payments are part of your contractual agreement with your insurance company. Co-payments will be collected at each visit. Deductibles and co-insurance balances are expected to be paid in full. If a payment plan is arranged through our billing office there is a minimum monthly payment of $100 required on balances that are $500 or greater and a minimum monthly payment of $50 is required on balances that are less than $500. ***Non adherence to this policy will result in collection proceedings.*** **_____ (initials)**

MANAGED CARE

You are responsible for obtaining a referral for office visits and office procedures if required by your insurance company. Often separate referrals will be required for examinations, diagnostic test and procedures. It is your responsibility to provide a referral with our office prior to seeing the provider. If a referral is NOT present at the time of your visit you will be required to reschedule your appointment or you will be required to pay out of pocket for services provided without a referral. When requesting your referral from your Primary Care Physician you must request they process an electronic referral as our office no longer accepts paper referrals.

HUNTERDON MEDICAL CENTER PATIENT ASSISTANCE PROGRAM (CHARITY CARE)

It is the policy of our office to allow a discounted rate for patients qualified for HMCPAP. You are required to pay $100 at each office visit, which is to be paid in full at time of check in. All procedures performed for the patient either in our office or at Hunterdon Medical Center are required to pay 60% of fees which are due prior to procedure being performed.

HMCPAP will **not** be accepted as secondary to ANY commercial carrier other than Medicare. The same requirement of up to $100 payment for each office visit and 60% of fees for procedures in and outside of the office after Medicare coverage applies.

SURGICAL PROCEDURES

For elective surgical procedures, APUH will contact your insurance company to determine coverage of benefits and prior authorization. All co-payments, deductibles and co-insurance will be collected prior to your scheduled surgery. If payment is not received before the date of the surgical procedure is scheduled, it will be cancelled or rescheduled.

RETURNED CHECKS

Any check returned for insufficient funds or a closed account will be assessed $30 service charge payable by cash or credit. This amount will be your responsibility in addition to the original unpaid charge. Failure to pay in full within 10 days of billing date may result in your account entering collection proceedings. You will be responsible for all costs incurred by APUH in our effort to obtain reimbursement for services provided.

COLLECTION AGENCY

If the patient responsibility portion of your account is over 90 days past due, you will receive a letter stating that you have 2 weeks to pay your account in full or enter collection proceedings.

MEDICAL RECORDS

A copy of your medical records created by APUH will be released only with your written consent. After completing the appropriate Authorization for Disclosure of Protected Health Information, please allow 7 – 10 business days to process this request.

FORMS

The completion of forms (school, temporary disability, disability, FMLA, etc.) require both physician and office staff time, therefore, there is a fee of $10.00 per form to be completed by our office. The fee must be paid prior to completing the form(s), please allow 5 – 7 business days for completion.

SELF PAY FINANCIAL POLICY

All cash patients and patients that present without valid insurance information are considered a Self-Pay Patient. All Self-Pay patients are required to pay at the time the service in the office is rendered and/or prior to procedures outside of the office. *We accept Cash, Checks, Discover, Visa and Mastercard for your convenience.*

PERMISSION TO CONTACT

Adult & Pediatric Urology of Hunterdon has my permission to contact me regarding my account at:

HOME PHONE: _____ at these convenient times: _____

MOBILE PHONE: _____ at these convenient times: _____

WORK PHONE: _____ at these convenient times: _____

All co-payments, co-insurances, deductibles, and outstanding balances must be settled before seeing the providers at Adult & Pediatric Urology of Hunterdon. Our office reserves the right to immediately cancel your care for conduct, non-cooperation or non-payment.

Your signature represents your acknowledgement of full financial responsibility and your understanding and acceptance of the policies of our office's financial contract detailed above.

_____ _____

Print Name of Patient or Responsible Party **Patient Date of Birth**

_____ _____

Signature of Patient or Responsible Party **Date**

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