Financial Policy

This form describes our financial policy which manages how we handle the financial aspect of the care, treatment, supplies, and other services you receive here.

- It is customary to pay all deductibles, co-insurance, and/or co-payments at the time of service. It is illegal for us to waive these charges. We do not accept a 'bill me later' policy. For your convenience we accept cash, checks, and most major credit cards.
- If your insurance cannot be verified at the time of service, your appointment will be rescheduled regardless of circumstances. It is your responsibility to provide proper and valid documentation.
- It is your responsibility to inform the office of any changes in your insurance coverage. We **WILL NOT** re-bill your insurance if you fail to keep us updated with the most current insurance information.
- At this time we are unable to verify benefits due to time constraints. You are responsible for knowing your benefits and will be responsible for contacting your insurance for details.
- Patients or Guarantors are financially responsible for any and all services provided that may not be covered by your insurance plan, as well as any insurance payment denials. Your health insurance is an arrangement between you and your insurer; you should understand what services are covered under your specific plan.
- Some insurance policies require a referral from your primary care physician. **It is your responsibility to ensure that we have your referral prior to your first appointment and that it remains current.** Failure to obtain your referral could result in self-payment.
- Delay in payment from the insurance company may result in a transfer of responsibility from the insurance company to self-payment. At that time you may pursue your insurance carrier to render payment. Once settled, if due, you will receive a refund for any overpayment.
- Our policy requires that all "patient-due" accounts (*once your insurance company has paid their portion of your claim, or from the time of service for self-pay patients*) over 90 days old will be referred to a licensed debt collection agency. In addition to being liable for your outstanding balance, any additional court costs and attorney fees required to collect the unpaid balance will be charge to you. **Furthermore, patients with an unpaid balance over 90 days that is greater than $50 will be discharged from the practice for financial non-compliance.**
- We are **NOT** Molina, DSHS, or Medical Coupon providers and do not accept any other state Medicaid programs even as a secondary to tertiary plan. * Some exceptions can occur and prior confirmation with our billing representative must be obtained.
- We send statements out monthly to all patients. **Balances are due in full upon receipt unless a payment plan has been established and signed.**
- **Cancellation policy:** Out of respect for our staff and other patients, we ask that you contact us as soon as possible if you must cancel a scheduled office visit. Reminder calls are made as a courtesy only. With the exception of an emergency, you will be charged a $30 cancellation fee if you fail to contact our office at least 24 hours prior to your appointment to cancel or reschedule an appointment. *The cancellation fee must be paid before another appointment will be scheduled.* Repeated 'no-shows' or failure to cancel appointments without giving at least 24 hours notice may result in discharge from our practice. Some office procedures will have a higher cancellation/no-show fee.

Attestation: Your signature (or the signature of your guardian) and that of the responsible party acknowledge that you understand and agree to comply and accept responsibility for all dates of service.

Patient Printed Name	Patient or Responsible Party Signature	Date

Responsible Party Printed Name

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT FORM

The law protects the privacy of the health information we create and obtain in providing our care and services to you. Your protected health information includes your symptoms, test results, diagnosis, and treatment health information from other providers and billing and payment information relating to these services. Federal and state law allows us to use and disclose your protected health information for the purposed of treatment and healthcare operations.

Acknowledgement Form:
I have received the Notice of Privacy Practices and I have been provided an opportunity to review this notice.

Signature: _____

Printed Name: _____

Date: _____

Mailed Documents:
It is our policy to mail a reminder postcard to our patients who have an appointment scheduled 90 days out or further. These cards may contain a brief reminder for pending labs or radiology requests.

Message:
With my signature below, I give permission to Washington Urology and/or his staff to the above statement and to leave messages regarding my health, appointments, and financial information on my answering machine **or with the following individuals (Please include their name and phone number):**

_____

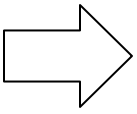
_____

_____

_____

Signature: _____

Date: _____

Facility Contact Person: The name and address of the person you can contact for further information concerning our privacy practices is:		**Kelly LaPierre** **471 Williams Blvd.** **Richland, WA 99354** **Phone: 509-946-8000**