

# SEATTLE UROLOGICAL ASSOCIATES PATIENT AGREEMENT – FINANCIAL POLICY

## **Co-pays**

The patient is expected to present an insurance card at each visit. All co-payments and past due balances are due and payable at the time of service. If we have to bill you for a co-pay, there will be a \$5.00 fee to cover administrative and postage fees.

## **Self-Pay Accounts**

Self-pay accounts are patients who are covered by insurance plans that the clinic does not participate in, patients without an insurance card on file, or at the time of service, do not meet the deductible. It is expected that payment is required at the time of service for all services and surgeries. A \$30.00 fee will be charged for returned checks.

## **Extended Payment Arrangements**

For procedures exceeding \$300: 75% of the total fee from an office visit is to be paid at the time of service, or 75% of the total fee for a surgical procedure is to be paid prior to the procedure. The remaining balance is to be paid over the next three months in equal monthly payments due by the first of every month. Patients who fail to make a monthly payment will be sent to a collection agency and may be terminated from the practice.

## **Non-Participating Insurance Plans**

The financial obligations of patients who are insured by carriers that the practice does not participate are considered a Self-pay account. The insurance company will be billed as a non-assigned claim as a courtesy to the patient with the patient paying the clinic the amount in full. The insurance company will reimburse the patient on non-assigned claims. If the clinic receives payment for a non-assigned claim, the patient will receive a refund within 10 days.

## **Automobile Accident Cases**

The patient will be treated as a Self-pay account unless a subrogation agreement is provided by health insurance. If a subrogation agreement is provided and the physician participates with the insurance carrier, the health insurance is billed. If an attorney is involved in the case, a letter of protection will be obtained whether an insurance carrier is involved or not.

## **Patient Refunds**

The following criteria must be met prior to issuing a patient refund: The patient has not been seen in the office for 90 days, there are no outstanding insurance claims on the patient's account, and there are no outstanding balances on the account.

## **Divorce Cases**

In cases of divorce, the individual who receives care is responsible for payment of co-pays, coinsurance, and nonparticipating insurance balances at the time of service. We will not bill a divorced spouse for the patient's services.

## **Child-Custody Cases**

The parent with primary custody is usually the parent with whom the child lives and who usually brings the child to the clinic for care. The custodial parent is responsible for payment at the time of service whether the account is considered self-pay, participating insurance, or nonparticipating insurance. If the non-custodial parent carries the insurance on the child, the clinic will bill that insurance company. The clinic does not get involved with divorce specifics, e.g., one parent

pays 80% and the other pays 20%. It is the parent's obligation to work out an agreement themselves or through the court system.

**Referrals**

If your insurance has designated a primary care provider (PCP), you are required to have prior authorization from your PCP prior to your clinic visit. If this authorization is not provided, you will be asked to either reschedule your appointment or pay for your visit at the time of service.

**Insurance Card**

Please bring your insurance card to the clinic at the time of your appointment. Without the presence of an insurance card, you will need to pay in full at the time of service. We will provide you with a receipt, which you may submit to your insurance company yourself.

This financial policy helps the clinic provide quality care to our valued patients. If you have any questions or need clarification of any of the above policies, please feel free to contact us.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date