FINANCIAL POLICY

At Spokane Urology, we understand that insurance billing can be complex, and our team of professionals are committed to providing you with the information and resources needed to understand your bill.

If at any time you have questions about your bill and what is covered by insurance, please contact our billing department at (509) 747-3417, option 2, Monday – Friday from 8:00am – 5:00pm.

Please read the following information carefully as these updates to our financial policy may impact your future appointments and scheduling for surgical procedures, treatments and injections. Patients will need to satisfy the following conditions in order for us to schedule your surgical procedure, treatment or injection, as well as your office appointment:

1. Surgical procedures treatments and injections: Prior to Spokane Urology scheduling any surgical procedure, treatment or injection, whether performed in our offices, surgery centers or by our physicians in any hospital, you will be required to make arrangements to pay all estimated out-of-pocket costs associated with your surgical procedure, treatment or injection in advance.

   The amount you will be required to pay will be determined based upon your individual insurance plan and will include any deductibles, co-payments and co-insurance which your insurance carrier indicates that you will owe. In addition, you will be required to make arrangements to pay any other outstanding balances that you may owe to us at that time.

2. Office Appointments: Prior to us scheduling your office appointment, you will be required to make arrangements to pay any outstanding balances that you may owe to us at that time.

Our billing department will work with you to provide assistance in satisfying any amounts that you may owe.

Fees for Services Rendered

We cannot waive co-payment, deductibles, co-insurance or any service amounts defined as patient responsibility under the terms of our contractual agreement with the insurance plans listed in our Billing Policy. You will be asked to pay on any past due balance at the time of check-in.

Your co-payment is due at the time of your visit. If you are unable to pay your co-payment, we will be glad to reschedule your office visit.

If we determine you have a deductible or co-insurance amount due, you may be asked to pay this amount at the time of your visit.

If you are required to obtain a referral from your Primary Care Physicians, it is your responsibility to bring this with you to your visit. If you do not have a referral, we will be glad to reschedule your visit so that you can obtain one. Patients seen without a referral may be subject to Out-Of-Network billing options.

As a courtesy, our office will assist you in obtaining pre-certification from your insurance plan, if it is required. However, insurances vary in coverage, and it is the patient's responsibility to understand his/her medical benefits and requirements. We recommend that you verify your insurance benefits for any procedures/tests scheduled. Failure to bring pre-authorization may result in lower or no payment from the insurance company, and the balance will be your responsibility.

It is the patient's responsibility to know if we participate with your insurance plan. If your insurance company is out of network with us, we are glad to submit a claim form on your behalf; however, you are responsible for payment in full.

During your medical treatment with Spokane Urology, including your office visit and/or surgical procedure, your urologist may request that a tissue, blood or urine specimen be obtained for the purpose of diagnostic testing. This testing is being performed in order to assist your urologist in the diagnosis and management of your urologic condition. Depending upon the requirements of your insurance coverage, these specimens may be processed at Spokane Urology's office laboratory or at a third-party laboratory, for example Quest or LabCorp. The costs of these laboratory tests vary depending upon the nature and complexity of each test. The cost for a diagnostic test, including the cost that you will be required to pay, if any, depends on your insurance carrier and the type of insurance coverage you have. Please note: 1) All charges for specimens processed at Spokane Urology's laboratory will be included in the statement you receive from Spokane Urology. 2) Charges for specimens processed at a third-party laboratory will be billed to you directly by that laboratory.

For self-pay patients, $300.00 is due at check-in. The account balance is expected to be paid in full upon check-out. We do our best to estimate your financial responsibility up front, but please understand this is only an estimate. If you feel you qualify for a financial hardship, please see our staff for the appropriate paperwork.

Motor Vehicle Accidents (MVA) Insured and Third Party Patients

We do not extend discounts for MVA-insured accidents, third party insurance claims or in other cases when patients may be reimbursed in full. We will bill the MVA insurance carrier one time. The bill becomes your responsibility if not paid by the carrier in 30 days. We regret that we are not in a position to confer with attorneys or defer payment obligations while a case settles. If your personal injury protection benefit on your MVA policy is exhausted, we will bill your private insurance at your request provided we are furnished the necessary information at the date of service.

Workers Compensation

If your visit is work related, we will need the case number and carrier name prior to your visit in order to bill the workers compensation insurance carrier.

Patient Refunds

If you have overpaid your estimated patient responsibility, Spokane Urology will process your refund after the claims for your procedure have been fully processed by your insurance company.

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN
I authorize the release of medical or other information necessary to process health insurance claims. I hereby authorize and request my insurance company to make payment directly to Spokane Urology and any wholly owned subsidiaries of any benefits that may be due for covered services and supplies rendered to me by Spokane Urology.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION
I hereby authorize my provider, Spokane Urology to release any information necessary for my course of treatment.

Signature:_____Date:_____