Bellingham Urology Group PLLC

FINANCIAL POLICY

Print Patient Name: _____

Patient Date of Birth: _____

We believe that part of good health care practice is to establish and communicate a financial policy to our patients. We are dedicated to providing the best possible care for you, and we want you to completely understand our financial policy.

_____**PAYMENT** is expected at the time of your visit. We will accept cash, check, or credit card. Payment will include any unmet deductible, co-insurance, co-payment amount, or non-covered charges from your insurance company. If you do not carry insurance, payment in full is expected at the time of your visit. We do ask for a copy of your Insurance Card and ID card/license due to the risk of identity theft.

_____**INSURANCE** We are participating providers with several insurance plans. We will file all of these insurance claims. A list of these insurance plans is available upon request and/or can be found on our website. Please remember that insurance is a contract between the patient and the insurance company and ultimately the patient is responsible for payment in full. If our doctors are not listed in your plan's network, you may be responsible for partial or full payment. If you are insured by a plan with which we have no prior arrangement, we will prepare and send the claim in for you on an unassigned basis. Your coverage will be determined as "out-of-network' benefits as dictated by your plan. Due to the many different insurance products out there, our staff cannot guarantee your coverage/benefits. Be sure to check with your insurer's member benefits department about services and physicians before your appointment.

Not all insurance plans cover all services. In the event your insurance plan determines a service to be "not covered", you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office. All procedures billed in this office are considered covered unless limited by your specific insurance policy.

_____**RETURNED CHECKS** will incur a $25.00 service charge. You will be asked to bring cash, certified funds or a money order to cover the amount of the check plus the $25 service charge to pay the balance prior to receiving services from our staff or the physician.

_____**FORMS FEES**: We require pre-payment for completing forms, notarizing, or for extra written communication by the doctor. The charge is determined by the complexity of the form, letter, or communication. Base form charges are $50 per occurrence.

_____**CANCELLATIONS OR MISSED APPOINTMENTS**: If you do not cancel your appointment at least 24 hours before, or if you no-show, we will bill you a $25 missed appointment fee. Similarly, if do not cancel with 24 hours or no show for a surgery, Urodynamics, or a procedure, we will bill you a $75 missed appointment fee. As a courtesy, appointment reminder calls, texts, and/or emails are made 24-48 hours prior to your scheduled appointment. Please provide us with the best phone number to contact you. In case of inclement weather, please call our office as soon as possible.

_____**NO SURPRISE ACT**: This act prohibits out-of-network providers and facilities from balance billing commercially insured patients above the allowed amounts set by their insurance carriers. Benefits will be made available before any appointment if asked for by the patient.

By signing below, I confirm that I have read this entire form and acknowledge this policy:

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Patient/Parent Signature Today's Date