MidLantic UROLOGY
Exceptional Care. Personal Service.

Financial Policy

MidLantic Urology is dedicated to providing quality patient care and is also aware that financial concerns are important too.

Before your visit, AU is required to verify your member eligibility with your insurance company. In addition, when you arrive for your appointment, for your protection and in accordance with federal regulations, AU is required to verify your identity (valid driver's license or other form of acceptable photo identification). If you are unable to provide an acceptable form of identification, this may cause denial of services. Please inform the front office staff if you have any concerns regarding your insurance benefits or if you do not have insurance coverage (self-pay). If you are self-pay, and are unable to satisfy your financial obligations to AU, you may want to contact your local health department to see If you are eligible for Medical Assistance. Please feel free to contact your MidLantic Urology doctor's office to discuss your payment options in advance of your scheduled appointment.

We recommend that you contact your insurance carrier for specific questions related to your Explanation of Benefits.

Note: Please be advised that we have a separate policy for self-pay patients with no insurance coverage. Please read the following carefully and sign below.

CO-PAYMENTS: Co-payments are due at the time services are rendered per your contract with your insurance company, if applicable. Payment can be made by check. cash, MasterCard, VISA, or Discover.

REFERRALS: Referral forms must be presented at the time services are rendered, if applicable. If you need a referral form to be faxed to us, our office will have a FAX number available for you to provide to your primary care physician.
FINANCIAL RESPONSIBILITY: You are responsible for all co-payments, deductibles, and charges not covered by health insurance. Without valid health insurance, full payment is expected at the time services are rendered.
ACCOUNT BALANCES: Our office provides you with monthly statements of all account activity including charges, payments and contractual adjustments. Failure to pay outstanding balances that are your responsibility may result in the practice forwarding your account to a collection agency or collection attorney and may result in additional fees to you, including attorney's fees. If your payment is returned due to insufficient funds or stopped payment, you will be charged the return check fee allowed by Pennsylvania Law.

MEDICARE PATIENTS:

THE FOLLOWING PROVISION APPLIES TO ALL PATIENTS WHO ARE COVERED 1) BY MEDICARE AND HAVE SECONDARY COVERAGE, OR 2) BY A MEDICARE ADVANTAGE PLAN.

By my signature below, I hereby authorized and request my insurance company to make payment directly to MidLantic Urology for any benefits that may be due for covered services and supplies rendered to me by MidLantic Urology.

I understand that the signing of this waiver does not negate my right to request further appeal under 42 CFR 422.600.

ALL PATIENTS

I certify that all information given is true. I understand that services rendered to me will be billed to the named Insurance Carrier. If the claim submitted is rejected, I will be responsible to pay the bill.

It is understood that any dispute as to unnecessary medical services, unauthorized, or improperly, negligently or incompetently rendered medical services or medical malpractice will be determined by submission to arbitration as provided by Pennsylvania Law and not by a lawsuit or court process except as Pennsylvania Law provides for judicial review of arbitration proceedings. Montgomery County jurisdiction is agreed and accepted in all filings and proceedings.

I authorize and direct MidLantic Urology or its designee to release to insurance carriers, authorized agencies of such insurance carriers or others who are financially liable for services and or medical care, all medical records and other information needed to substantiate payment for such. My signature below indicates that I have read and understood the above.

Print Your Name _____ Date of Birth _____

Sign Your Name _____ Date _____