Central Ohio Urology Group, Inc.
Financial Policy

We are committed to providing you with the best possible medical care. If you have special needs, we are here to work with you. The following information is provided to avoid any misunderstanding or disagreement concerning payment for professional services.

1. Our practice participates with a variety of insurance plans. It is your responsibility to:

    - **Bring your current insurance card at every visit**. We consider an insurance card similar to a credit card because you are asking us to bill another party for charges for the services you have been provided. If you do not bring your insurance card, you should be prepared to pay for your services in full on that date.
    - **Be prepared to pay your copay at each visit**. We are required by your insurance plan to collect copays on the date of service. Payment can be made by cash, check, or credit card. If you do not bring proper payment to your visit, you will need to reschedule your appointment except in the case of a medical emergency.
    - **For medical care not covered by your insurance, deductible and coinsurance limits that have not been satisfied, or for patients that have no insurance, payment in full is due at the time of the visit**.

2. If you have insurance that we do not participate in, upon request our billing office will provide you with a form with itemized charges that you can use to file to that plan for reimbursement. However, payment in full is expected on the date of service.
3. If you have secondary insurance coverage, you must provide that information on the date of service. You will be expected to pay any copay required by your primary insurance on the date of service. If you do not provide us with your secondary insurance information in order to file a timely claim, you will be responsible for any balance due after your primary insurance pays.
4. If you are unable to pay for necessary medical care, you may be eligible for financial assistance. It is your responsibility to inform us prior to your visit.
5. Referrals: It is your responsibility to bring any required referrals for treatment at, or prior to the visit. If you do not have the referral, your visit may be rescheduled, or you may be financially responsible.
6. If the patient is a minor (under 18 years of age), the parent or guardian must sign below. The parent, guardian, or unaccompanied minor is responsible for any payment due at time of service, bringing the necessary referrals and insurance card.
7. A “Facility Fee” may be charged according to our contracts with certain commercial and government plans. If you are covered by any of those plans, you will be responsible for any portion of the “Facility Fee” that is not paid by those plans according to your benefits.
8. If you have any questions about insurance, we are happy to help you. Specific coverage issues, however, should be directed to your insurance company customer service department (the number is on your insurance card).
9. If you fail to show up for an appointment without contacting us to cancel your appointment at least one day in advance, your account may be charged a no-show charge.
10. If you fail to make payment in full for the services that are rendered to you, your outstanding balance will be sent to a collections agency. You will be responsible for the fees assessed by the collections agency.

Our practice believes that a good physician-patient relationship is based upon understanding and good communication. Questions about financial arrangements should be directed to the office where you regularly receive services. Please sign that you have read and agree to the Financial Policy.

Signature of Patient or Responsible Party　　　　　　　　　　Date

Signature of Co-Responsible Party　　　　　　　　　　Date