Financial Policy

Thank you for choosing our practice. We are committed to the success of your medical treatment and care. For your convenience, we have answered a variety of commonly asked financial questions below. If you need further information or have any questions about any of these policies, please do not hesitate to contact us at 540-667-1712.

How can I pay for medical services?

- Cash, check, Visa, Mastercard, Discover
- There will be a charge of **$30.00** for returned checks

What is my financial responsibility for medical services?

If you have commercial insurance (PPO or HMO) our office **participates** with:

- All co-pays, deductibles and coinsurance amounts are your responsibility. Co-pays are due at the time services are provided along with any outstanding deductibles and predetermined coinsurance amounts. Our staff will do their best to determine ahead of time your co-pays and any outstanding deductibles or coinsurance. Should there be a balance after we have filed your insurance claim; payment in full is due within 30 days of your receiving a statement from our office.

If you have a commercial insurance (PPO, HMO or out of network plan) that our practice **does not participate with**:

- You are responsible for payment in full of all services rendered at the time of service. Our staff will file an insurance claim to your insurance carrier as a courtesy.

If you have Medicare only:

- You are responsible for 20% of the approved Medicare allowable and any outstanding Medicare yearly deductible at the time of service. Should you wish to have services not covered by Medicare, our staff will notify you prior to providing the service and you will have the option to receive the service and you will be responsible for payment.

If you have Medicare primary and a commercial insurance secondary:

- No payment is required at the time of service

If you have a Medicare Advantage Plan:

- You are responsible for your co-pays at the time of service. Should you wish to have services not covered by Medicare, our staff will notify you prior to providing the service and you will have the option to receive the service and you will be responsible for payment.

If you have Worker's Compensation:

- If our staff has verified the claim with your Worker's Compensation carrier, no payment is required at the time of service. If we are unable to verify your claim prior to service being rendered, payment in full is required.

If you have Virginia Medicaid:

- If your Medicaid is verified and valid on the day service is rendered, no payment is required. If we are unable to verify your Medicaid prior to service being rendered, payment in full is required.

If you have WV Medicaid:

- Urology Clinic of Winchester **is not** accepting new patients

If you do not have insurance:

- We ask that you be prepared to pay at least **$100.00** and then set up regular monthly payment arrangements. We can set up recurring monthly credit card payments if this would be convenient for you.
- **OR** you can pay for your visit/visits in full each time you are seen and receive a 30% discount on the daily charges.

Collection Policy

I understand if I have insurance and have provided accurate and complete information regarding my insurance, my charges will be filed with my insurance carrier; however, the financial responsibility for services rendered to a patient ultimately rests with the patient or responsible party. I understand that my co-pay and/or any coinsurance monies are due at the time of service. If I do not have insurance or my charges are not to be filed with insurance, payment in full is due at the time of service. In the event legal action should become necessary to collect an unpaid balance due for medical services rendered to me, I agree to pay all collection fees and any court costs, in addition to the outstanding balance.

No Show/Cancelation

I understand that the practice charges **$50.00** for all no-show office appointments
I understand that the practice charges **$100.00** for all no-show office procedures.

I have read this financial policy and agree to these terms.

Patient Signature_____**Date** _____

Print Patient Name _____

Guardian Signature (if applicable) _____