Financial Policy for North Idaho Urology, PLLC

North Idaho Urology is committed to providing high-quality, comprehensive health care and personal service to our patients. For every commitment, there is an obligation. It's the patients' responsibility to meet their financial obligations.

The following financial policy is being provided to avoid any future misunderstanding. If you have any questions regarding this policy, please discuss them with our staff prior to your appointment. We're dedicated to providing the best possible care and service to you.

- Patients are responsible for providing accurate insurance information at the time of registration, and understanding their insurance coverage, co-payments, deductibles, and other financial obligations associated with medical services received.
- Copayments will be collected upon check-in for your appointment. Failure to provide your copayment may necessitate rescheduling of your appointment.
- We will submit claims to the patient's insurance company on their behalf. However, patients are responsible for ensuring that claims are processed and paid by their insurance company.
- Our services are elective and may require payment prior to receiving the service. Our office will inform you of the amount due that will be collected prior to or on the date of service. We will refund any overpayments to you after the insurance pays their portion for the service.
- Some services require specimens to be sent out to laboratories that may be out of network with your insurance, of which we do not do authorization or billing for such services.
- Patients without insurance coverage (self-pay patients) are required to pay a downpayment of $271.00-343.00 for medical services at the time of each service.
- Patients will receive itemized billing statements for medical services rendered. Statements will be sent via mail or email, depending on the patient's preference.
- We offer payment plans to assist with your patient balance. Please contact the billing department to discuss available options. Payment plans in default will be turned over to an outside collection agency. Accounts that are past due may be subject to collection actions, including but not limited to, third-party collections, reporting to credit bureaus, and legal action.
- In order to provide the best possible care and to ensure availability of our services to patients, please call as soon as possible if you know you will need to reschedule or cancel your appointment. If you do not cancel or reschedule an appointment for a procedure or surgery, 24 business hours prior to the scheduled procedure or surgery, you will be billed $200 per occurrence. If you miss your office visit appointment without notifying us 24 hours (during business days) prior to your appointment, you will be charged $50.00 for that missed appointment.
- In the event that your health plan determines that a service or supply is "not covered", you will be financially responsible for that service or supply. Payment is due upon receipt of a statement from our office. Payment for certain services / supplies may be required at the time of the visit.
- Charges will apply for the processing of disability forms, life insurance policy application forms, FMLA, and other related forms at $25 per packet of forms.
  Forms will need to be picked up personally; we will not fax or mail these forms.
- Charges will apply for pre-authorization of your insurance for uncovered medications. Medication pre-authorizations will be $25 per authorization. There is no guarantee that coverage will be obtained by the prior authorization attempt.

If you are uninsured or out of network at the time of service, it is our policy that you pay $343 as a new patient or $271 as an established patient at the time of service and we will bill you for any remaining charges, except for ELECTIVE procedures, which are collected in full. Payment is accepted by cash, check, Visa or MasterCard, and Care Credit.

Accreditation Commission for Health Care Toll-free (855) 937-2242

I have read and understand the financial policy of North Idaho Urology PLLC, and I agree to be bound by its terms. I also understand that such terms may be amended from time to time by North Idaho Urology PLLC, without notice.

Signature: _____ Print Name: _____
Date: _____