Payment Policy

Thank you for choosing Urology Associates of SENC, PA as your healthcare provider. We are committed to providing you with quality and affordable healthcare. Please be sure to carefully read our payment policy. A copy can be provided upon request.

- **Insurance:** We participate in most insurance plans, including Medicare. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage. If your insurance requires an authorization, it is your responsibility to ensure that you are authorized on the day of service.
- **Co-payments and deductibles:** This arrangement is part of your contract with your insurance company. Co-pays and deductibles must be paid before seeing the practitioner. If your insurance company has not paid your account in full in 45 days, the balance is your responsibility.
- **Non-covered services:** Please be aware that some of the services you receive may be non-covered or not considered reasonable and necessary by Medicare or other insurers. You must pay for these services in full at the time of service.
- **Proof of Insurance:** All patients must complete a patient information form before seeing the practitioner. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.
- **Claims submission:** We will submit your claims and assist you in any way we can to help get your claims paid. Please be aware that any unpaid balances are your responsibility.
- **Coverage changes:** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefit.
- **Minor Patients:** The adult accompanying a minor and the parent (or guardians of the minor) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless payment at the time of service has been verified.

Consent to Medical Treatment

I have reviewed and consent to the following:

- I voluntarily present for treatment and consent to my provider to provide my care. Such care may include, but is not limited to, diagnostics procedures, blood draws, laboratory tests, medication administration, and other procedures considered advisable in my diagnosis, treatment and course of care.
- I acknowledge that my treatment is intended to address specific illnesses and is not intended as a substitute for a primary care physician and that no guarantee can be made or has been made as to the result of treatments or examinations at Urology Associates of SENC, PA.
- In the event an employee has a needle stick or otherwise is exposed to my blood or body fluids, I consent to testing for HIV or Hepatitis C & B.

By signing below, I acknowledge that I have reviewed Urology Associates of SENC, PA's payment policy and consent to medical treatment.

Print name of person signing: _____ Relationship to Patient: _____

_____ _____

Signature of patient (or guardian) Date