UNIVERSITY UROLOGY ASSOCIATES of New Jersey
UUANJ

FINANCIAL RESPONSIBILITY

We will make every effort to work with you and your insurance carrier to maximize your health care benefits. It is your responsibility to provide us with accurate and current insurance information at the time of each of your appointments. Please bring your current insurance information with you to each of your services. We regard your complete understanding of your financial obligation an essential element of your care.

APPOINTMENTS: Our office's automated system will call or text ahead of time to remind you of your scheduled appointment. It is the patient's responsibility to remember their appointment and to supply our practice with 24-hour notice if you must cancel your appointment. **Our office will charge a $50.00 missed appointment fee for each missed appointment**.

COPAYS & CO-INSURANCE: All copays & co-insurance are due at the time of service. This is a contractual agreement between you, your insurance, and our practice. If you are not able to meet your financial responsibilities, your appointment will be rescheduled. Please contact your insurance for your benefit allowances. Copays & co-insurance may be higher for specialty services.

DEDUCTIBLES: Deductibles may or may not apply to our services so it is important that you verify your benefits before services are rendered. Based on your insurance benefits, you may be responsible for the cost of the services performed based on the amount of your deductible at the time services are rendered. In these instances, we will request payment or a secured credit card at the time of your appointment. Please contact our office prior to your appointment if you have any questions after you have verified your deductible with your carrier.

PAYMENT PLAN: Patients with a high deductible plan and/or high account balances may qualify for a short-term payment plan. You may be required to have an active credit card on file. Please contact our billing office to discuss.

INSURANCE: Patients must provide all current insurance information at the time of service including presenting their insurance card, proof of identity, and social security number (when required). Patients arriving for their appointment without their insurance cards will be asked to reschedule or remit payment in full. If you are asked to pay in full and insurance information is later obtained and the services are covered, a refund will be issued to you. The patient is responsible for knowing the details of their insurance policy and benefit plan. Any changes to your insurance plan or information should be communicated to our office. UUANJ is not responsible for obtaining your benefit information.

INSURANCE CLAIMS: You will be responsible for any charges that your insurance doesn't cover within 45 days of submission. It is your responsibility to follow up with any unpaid service claims and balances. The patient is responsible for paying for any non-covered services. We can bill primary insurance and a secondary insurance. We do not file third insurance plans.

PAST DUE AND/OR COLLECTIONS: A service fee of 1.5% per month or 18% per annum will be applied to your balance if the balance is not paid in full within 90 days from the date the first statement is issued. If your account becomes delinquent or if our attempt to secure the balance or payment fails, the account will be reviewed for placement with a collection agency. If your account is forwarded to an outside collection agency, there will be an added fee of $30.00 added to the account balance. Monthly statements are issued to all patients with an account balance and payment is due upon receipt of the statement. Patients are responsible for all court fees related to balance collections, unless otherwise ordered by a judge.

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REFERRALS/AUTHORIZATIONS: Your insurance may require you to obtain a referral or authorization from your primary care physician before you seek services with a specialist. The patient is responsible for contacting the primary care physician to obtain the referral. Our practice is not permitted to see patients without a valid referral per our contractual agreement with carriers. You will be responsible for all denied charges if seen without a valid referral.

PAYMENT METHODS: UUANJ accepts payment by cash, money order, check, or credit/debit card. We accept Visa, Mastercard, and Discover. There will be **a 3% service charge added to all card payments**. **There is a $30.00 service fee for any returned check.** The balance due and the service fee will be required to be paid by the patient in form of a credit/debit card, money order, certified check or cash payment. A personal check for a returned check will not be accepted. We accept payment in-person, over the phone, by mail, or you may use our secure online payment system at billpay.uuanj.com.

SELF PAY PATIENTS: Patients who do not have an active or verified insurance plan will be required to pay for services at the time of the service. If you provide us insurance information after the service date, but before the timely filing limitations of that insurance, we will file the claim and reimburse you once your insurance accepts the claim.

MEDICAL RECORDS REQUEST: Our office will provide you or another entity on your behalf a copy of your medical records. You will be required to complete a release of information which can be obtained from our office. **Medical records requested will cost the patient $1.00 per page plus our processing fee of $10.00.**

DISABILITY / FMLA / LIFE INSURANCE FORMS: There will be a one-time processing fee in the amount of $50.00 for the completion of any disability or FMLA paperwork per form. The processing fee will be due the day you present the forms which includes forms sent via online or fax submittal. Any special instructions need to be attached to the form(s).

FINANCIAL ASSISTANCE: Our practice cannot offer financial assistance to patients with active insurance plans. This is due to a contractual agreement we have with your carrier that states patients will be responsible for paying coinsurances, deductibles, and copays as set forth in your policy benefit plans.

I, the undersigned, hereby agree that I have read and understand each of the above financial policies stated. This policy supersedes any verbal agreements or waivers. If I have financial questions or concerns, I will contact the billing office to discuss them. I agree to be financially responsible for any balance due related to services rendered by University Urology Associates of New Jersey or its partners.

⇨ _____ _____

Print Patient Name **Date**

⇨ _____

Patient Signature