**Advanced Urology Institute**
RAMOS, HEALEY, BEISWANGER, EISENBROWN, JENKINS, HITT, JAMES WILKINS, PA-C,

80 Doctors Drive – Panama City, FL. 32405 – Phone 850-785-8557 – Fax 850-785-1123

625 W. Baldwin Road, Suite 1 – Panama City, FL.32405

**Financial Policy**

As your physician, we are committed to providing you with the best possible medical care. In order to achieve this goal, we need your assistance and your understanding of our payment policy.

**PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED.** We accept cash, personal checks, MasterCard, Visa, Discover, and American Express as payment for office services deductibles, copays and co-insurance.

**PRIVATE INSURANCE COMPANIES THAT WE “ARE” A PROVIDER WITH.** Co-payment and deductible must be paid at the time of service. If we are unable to verify your insurance coverage, you may be responsible for full payment at the time of the service. Because we are under contract with the insurance company, we will file your insurance claim. If payment is not received from your insurance company within a reasonable time, the full balance will be transferred to the responsibility of the patient (or guardian).

**Please note that if you do not provide us with the correct, current insurance information at each date of service, you will be responsible for any charges incurred.**

**PRIVATE INSURANCES COMPANIES THAT WE “ARE NOT” A PROVIDER WITH,** You will be responsible for payment in full at the time of service and our office will file the claim form as a courtesy with your insurance company.

**Self Pay- For our patients who do not have insurance coverage, we will require a $150 deposit each visit that will go towards your date of service. The patient is solely responsible for all charges from the date of service rendered. Our billing office is available to discuss your account and setup up payment options after all charges have been processed.**

**Surgical Services:** Payment of co-pays, deductibles and co-insurances will be collected prior to surgery. If requested, a written estimate of charges will be given to you along with the patient’s estimated balance owed after insurance has paid. We will file with third payers for the assigned insurance balance only.

**Hospital Services:** Payment of co-pays, deductibles and co-insurances will be collected before hospitalization. If requested, a written estimate of charges will be given to you along with the patient’s estimated balance owed after insurance has paid. We will file with third payers for the assigned insurance balance only.

**Non-Payment Accounts**: Any insurance balance will be billed to the insurance carrier. If the insurance carries does not pay, you will be responsible for the payment. Any balances with no payment activity will be forwarded to a collection agency.

**Missed Appointment**: We ask for 24 hours’ notice to cancel an appointment. Patients who do not call to cancel an appointment may be charged $25.00. A third no show may result in the patient being discharged from the practice.

**Forms and Records:** For completion of disability and cancer policy forms, there will be a $10.00 charge for a one-sided form and $15.00 charge for a two-sided form. Medical records requested will have a charge of $1.00 per page for the first 25 pages, and twenty-five cents for every page thereafter. Forms and records will be released only after payment has been received.

**Financial Agreement:** We will gladly discuss your proposed treatment and do our best to answer any questions relating to your insurance. You must realize, however that:

1. Your insurance is a contract between you and the insurance company. We are not party to that contract.
2. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover (such as elective sterilization, infertility evaluation screening lab test, etc.).

We must emphasize that as your medical care providers, our relationship and concern is with you and your health, not your insurance company. **ALL CHARGES ARE YOUR RESPONSIBILITY FROM THE DATE SERVICES ARE RENDERED.** On any balance on your account over 90 days, including those that your insurance has not paid, collection action will be taken. We realize that emergencies do arise and may affect timely payment of your account. If such extreme cases occur, please contact our billing department at (850)785-8557.

If you have any questions about the above information or any uncertainty regarding insurance coverage, please do not hesitate to ask us. We are here to help you.

**My signature below certifies that I have read and understand the terms of the financial policy.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Print (Patient, Guardian, or Power of Attorney) Date of Birth**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Signature (Patient, Guardian, or Power of Attorney) Date**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Witness Date**

Revised 7-14-17