

## **Financial Policy Children's Urology of the Carolinas**

Thank you for choosing us for your pediatric urology care. The following is our financial policy, which we require you to read and sign prior to any treatment. All patients/families should complete our Information and Insurance form prior to seeing the doctor. Copayments are due at the time of service. We accept cash, check, money order, or credit card (MasterCard or Visa only).

### **Insurance Plans**

No matter your plan, we will file your insurance at time of service. Regardless of type of health insurance, you are responsible for all non-covered expenses, co-pays, and deductibles. You are responsible for obtaining any required authorization prior to your appointment. If it is not obtained, and your child's condition is not emergent, we may reschedule your appointment. You are responsible for knowing what is covered by your insurance company's plan. We charge what is usual and customary for our region. Some, and perhaps all, of the services provided by us may be non-covered by your insurance company.

### **NC Medicaid**

You are responsible for providing us with an active Medicaid card at each visit. We do not accept pending Medicaid applications as proof of coverage.

### **SC Medicaid**

We only accept straight SC Medicaid. If you are in a managed care plan, you must switch to straight or pay full price for your visit. If you cannot do either, then you may need to see a doctor that is in your managed care network.

### **Surgery Pre-certifications and Deposits**

We will obtain pre-certification for surgery from your insurance company. You must provide us with current and all insurance plan(s) coverage before your surgery. You will be notified if a pre-surgery deposit is required for procedures done in the office or in the hospital. After your insurance processes your claim, you may receive an invoice for additional payment due or may receive a refund for an overpayment.

### **Divorce**

Divorce decrees are only binding between the two parties who made the agreement. It is our policy that the parent or guardian accompanying the patient is the responsible party for arranging payment.

### **Social Security Number**

We must obtain the social security number of at least one parent at the time of service. If you chose not to provide us with this information, credit cannot be extended and payment of anticipated charges will be collected at check in.

Thank you for understanding. We will be happy to assist with any questions you may have.

I have read the Financial Policy and was able to ask appropriate questions as necessary. I understand and agree to accept these Financial Policies.

X \_\_\_\_\_ Date \_\_\_\_\_

Print Name of Responsible Party \_\_\_\_\_