FINANCIAL ARRANGEMENTS AND INSURANCE PAYMENTS

It is necessary that you show us current insurance identification cards at the time of service. We will need to make a copy of these cards. We are providers for several insurance companies, but not all. *You* are responsible for verifying that we are providers for your plan. With insurance plans where we have agreed to participate in the network as a provider, your carrier requires all co-pays and deductibles be paid *prior* to any service being rendered. This co-pay/deductible *can not* be waived. You are also responsible for any non-covered service not paid by your insurance with the state's required time limitation for paying health care claims. You will receive a statement from our office indicating what your insurance has paid and what patient responsibility; this balance is due upon receipt.

Co-payments are a contractual obligation with your insurance company. ANY CO-PAYMENT OR DEDUCTILBES THAT YOU ARE RESPONSIBLE FOR IS DUE AND PAYABLE AT THE TIME OF SERVICE.

If you have insurance coverage with any of the following insurances listed below please let the receptionist know immediately. This will aid us in correctly filing your claims for reimbursement and also help us to route any other medical services to a participating provider

We are participating providers with the following groups:

OKLAHOMA HEALTH NETWORK
PREFERRED COMMUNITY CHOICE- BENEFIT CONCEPT, GREAT WEST (ONLY IF IT SAYS PCC)
HEALTHCHOICE
BLUE CROSS AND BLUE SHIELD PPO
MEDICARE
RAILROAD MEDICARE
OKLAHOMA MEDICAID/SOONER CARE- referral required if applicable

If you DO NOT have any of the insurance coverage listed above, we consider you a private pay patient. As a courtesy to you, we will very gladly file your claim. HOWEVER, you are still responsible for full payment of your bill at the time of service.

If you have no insurance at all, you are fully responsible for the account balance the same day as you are seen unless payment arrangements have been made with our financial counselor/billing department.

WE WILL GLADLY ACCEPT CASH, CHECKS,
CREDIT CARDS (*Visa, MasterCard*) and DEBIT CARDS.
PAYMENT ARRRANGEMENTS CAN BE MADE ONLY WHEN APPROVED THROUGH OUR BILLING DEPT.

Our office will submit your claims for you to your insurance and we will, *within reason*, attempt to help you get your claims paid. Your insurance company may need you to supply them with certain information directly. It is *your* responsibility to do so and if your insurance denies your claims due to your non-compliance, you are fully responsible for the bill and you will also be responsible for re-sending those claims to them for the dates of service in question.

Workers' Compensation: If your injury is due to an accident at work, we must receive your employer's information (name, address, phone, contact person) before we can process any of the medical claims. Denied claims will become your financial responsibility. If you fail to provide the necessary workers compensation and insurance information *at the time of your visit*, you will be financially responsible for all charges.

Medical Records: We will provide you with a copy of your medial records upon request. You must sign a medical records release and allow at least 7-10 days for us to comply with your request. If we mail any records to you, there may be an additional fee to cover postage. We do not fax medical records due to it is a HIPPA violation to do so. You may be charged medical records fee which will be within the Oklahoma state statues.

In order to release any medical information to your insurance company, it is necessary that you read and sign the following authorization:

I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE BENEFITS AND /OR INSURANCE AND /OR MEDIGAP BENEFITS BE MADE TO ENID UROLOGY ASSOCIATES, INC
(Dr. Worthen, Colvert, Kruska , Madelyn Keck A.R.N.P.)

I AUTHORIZE ENID UROLOGY TO BE RELEASE MY MEDICAL INFORAMTION TO HEALTH CARE FINANACING ADMINISTRATION AND ITS AGENTS OR INSURANCE COMPANY TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES.

** Please ensure you have read the above information regarding insurance & financial responsibility **BEFORE** signing below. By signing below, you agree to all terms and conditions described on this form.

PATIENT SIGNATURE_____**DATE**_____