

FINANCIAL POLICY

Complete insurance information is required for our office to file a claim to your insurance company. If this information is not provided at the time of your first visit, we will require payment in full.

HMO/PPO Insurance Plans

We will file all claims for HMO and PPO patients. We do request payment of any co-pay at the time of your visit. We must have your insurance card, billing information and current referral to submit a claim for you. This will be required at the time of your visit. You will receive a statement after your insurance pays, identifying portions defined by your insurance to be your responsibility. We request payment of the balance upon receipt of your statement.

Individuals without medical insurance

We require payment in full at the time of service from patients who do not have medical insurance. Those who need to make payment arrangements must do so prior to your visit. Please contact our billing department at 303-247-1968 and speak with a representative.

Medicare/Secondary insurance

Alpine Urology, P.C. participates with Medicare. We file all claims on your behalf. If you have a secondary insurance, you are responsible for submitting your claim to your insurance carrier. Alpine Urology will provide the medical claim forms needed for your filing.

Injury related claims (Workers' Comp, Auto and Personal Injury)

We file workers' comp, auto and personal injury claims on your behalf. You must have a valid workers' compensation/auto claim number in order for us to file a claim. If you do not have a claim number at the time of your visit, you will be rescheduled for a later date.

Billing/past due amounts

We will bill once per month and request prompt payment upon receipt of your bill.

Customer hereby acknowledges and agrees that any account that becomes delinquent will be subject to collections service. Customer agrees to pay all court costs and reasonable attorney fees for collection of all past due amount owed, plus interest thereon at 18(eighteen) percent per annum on all such amount outstanding.

Patient Signature: _____ Date: _____

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I received Alpine Urology's Notice of Privacy Practices.

Patient Signature: _____ Date: _____