NORTH DALLAS UROLOGYASSOCIATES / MCKINNEY

William C. Mitchell, MD
Jared D. Stringer, MD
972-548-8195

PAYMENT POLICY

Upon contact with our business office, we will request your insurance information. We are required by many insurance companies to get pre-certification numbers and benefits. This protects you as well as us from having unexpected out-of-pocket expenses. Our staff will call your insurance company to verify your benefits and also check on your current deductible, co-payment, and coinsurance. This information will be shared with you. In order to control our billing costs, we request the deductible, co-payment, and/or coinsurance be paid as they relate to the charges at the time of service. Payment may be made by cash, check, MasterCard, Visa, Discover, or American Express.

MEDICARE PATIENTS

If your primary insurance is Medicare, then we will file the claim for you. We do accept Medicare assignment which means we will bill you only what Medicare allows. Medicare will pay 80% of the allowable, minus any deductibles, and you will be responsible for the other 20% allowable plus any remaining deductible. If you have a secondary insurance policy, we will file that for you as a courtesy. Some secondary insurance policies reimburse directly to the patient and/or insured. If your insurance company does this, please forward the payment to us in the form of cash, check, or credit card.

MANAGED CARE PATIENTS

We request you pay your co-payment at the initial onset of your visit. If your deductible has not been met for the year, you will also need to pay any unmet deductible for the services rendered. After your deductible has been met, you will then be responsible for only your co-payment and/or coinsurance. Any procedure done may be subject to an additional surgical deductible depending on your particular insurance plan. We ill file all claims for the services rendered by the physician.

Assignment of insurance benefits, deductible, co-payments, and/or coinsurance are required before elective surgery. We will try to fulfill all insurance requirements for pre-certification; however, we cannot be responsible for reduction in benefits if this is not done. Therefore, we encourage you to contact your insurance company before any surgical procedures are done.

Please be advised that we request 24-hour cancellation notice prior to your scheduled appointment.

Assignment of Benefits

I authorize release of medical records to determine liability for payment and to obtain reimbursement. I assign all medical and/or surgical benefits including Medicare, private insurance, and other health plans to my physician. This assignment will remain in effect until revoked by me in writing. I understand I am financially responsible for all charges incurred by myself and/or my dependent.

Signed:____Date:_____________________

Parent or guardian if patient is a minor:____

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