

160 MacGregor Pines Drive, Suite 205
Cary, North Carolina 27511
(919) 851-5482 Fax (919) 851-4018

2800 Blue Ridge Road, Suite 405
Raleigh, North Carolina 27607
(919) 851-5482 Fax (919) 881-0752

NORTH CAROLINA UROLOGICAL ASSOCIATES, INC.

FINANCIAL POLICY

Our Financial Policies are explained below in order to help you better understand the financial aspects of your healthcare and to clarify any questions that you may have regarding your bill for services provided by North Carolina Urological Associates. If you have any questions, please speak with the front desk staff or a member of the business office staff

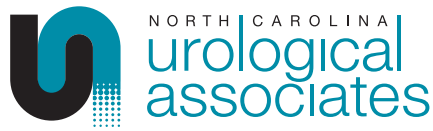
1. It is the patient's responsibility to know the benefits provided under their insurance plan. It is not possible for NCUA to know in advance what a particular plan covers or does not cover. If you have questions about coverage, please contact your insurance company prior to your visit.
2. Patients **must** provide a copy of your insurance card and drivers license at check-in for every visit.
3. We will gladly file your insurance if our office participates with your individual insurance plan. Our front desk staff will be able to tell you if we participate with your plan. If we do not participate with your insurance, you will be asked to pay in full at the time of service. We will file your insurance as a courtesy and any payment provided to us will be refunded immediately to you.
4. Patients will be responsible for any deductibles, co-pays or co-insurance amounts at the time of service. NCUA accepts cash, check, money order, Visa and MasterCard.
5. Self-Pay patients must pay \$100.00 upon check-in and the balance at check out. If your visit is less than the \$100, the difference will be refunded at check-out. Self pay patients who pay in full at the time of service will receive a 40% discount. Those unable to pay in full at the time of service will not receive the discount and will be asked to see a patient representative at check-out to set up a payment plan.
6. We will allow sufficient time for your insurance company to respond to our claim, which is usually within sixty (60) days. If your insurance company has not responded within sixty (60) days the amount of the claim will become the patients responsibility.
7. NCUA will file your secondary insurance unless you know that they pay you directly. In this event, you are responsible for your balance after your primary insurance company has paid the claim.
8. We send statements out monthly to all patients. **Balances are due in full upon receipt unless a payment plan has been established.**

Marc D. Benevides, M.D.
Douglas C. Leet, M.D.

Brian C. Bennett, M.D.
Stephen F. Shaban, M.D.

Timothy P. Bukowski, M.D., FAAP, FACS
Barbara A. Reynolds, FNP-BC

Diplomates of the American Board of Urology



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- 9. All patients who are members of an HMO or PPO insurance plan must verify with the receptionist before your visit that you have a current authorization. **If you do not have an authorization in our office at the time of your visit, you will be asked to either reschedule your visit or sign a waiver and pay for your visit in full at the time of service.**
- 10. In the event your health insurance plan determines a service to be “non-covered”, you will be responsible for payment of this charge.
- 11. Refunds – Office surgery holding deposit will be refunded within two weeks of your surgery. Otherwise, our refunds are processed once a month and any balances due to either patient or insurance company will be processed accordingly.
- 12. A \$30 service charge will be applied to your account for all returned checks. If we receive a return check from you, we will ask that you pay in cash, money order, MasterCard or Visa.
- 13. Divorce or Separation cases – We do not get involved with any legal aspects of a divorce or separation agreement. The parent seeking our services will be responsible for payment of services regardless of your court order. We will provide a receipt for proof of services.



I have read and understand the NCUA insurance and billing policies. My signature below represents my acceptance of the above policies.

Signature: _____ Date: _____

Name (Print): _____

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