Financial Policy

It is important that you understand your individual health plan and what it covers, including deductibles, coinsurance and copays. Call the customer service number on the back of your insurance card or contact your employer's benefits department to verify your coverage and for any questions regarding your health insurance plan.

1. **Assignment of Insurance Benefits:**
   I request and authorize that any and all insurance benefits due and payable for medical services rendered to me are to be paid directly to Urology Surgery Center Northwest.
2. **Financial Agreement:**
   I agree that my insurance coverage is a contract between myself and my insurance company. USCNW is not responsible for services denied by my insurance company. I agree to pay for services rendered at the ASC, which are not paid or excluded by any other Payer, in accordance with the regular rates and financial policy of the ASC. It is understood and agreed that my account is due and payable upon billing. I understand that I will receive notification of any overpayments made and I will be refunded my overpayment once a correct claim has been processed unless I have outstanding balances on other dates of service.
3. **Self-Pay:**
   I understand that if I do not have insurance coverage, I am responsible for the full amount billed for my date of service. All fees for cash pay cases must be paid in full by credit card, debit card, or certified check before surgery. If a patient wishes to pay by personal check the fee must be paid 10 days in advance of the procedure to allow time for the check to clear the bank.
4. **Patient Balances:**
   The USCNW Financial Policy requires all balances to be paid in full no later than 60 days after the initial billing statement. If I experience circumstances beyond my control, I can contact the Business Office at (509) 245-6858.
5. **Facility Estimate:**
   I understand that if I received a facility estimate prior to my procedure, I realize that it was only an estimate of my financial responsibility, not a final bill for my date of service.
6. **Financially Responsible:**
   I understand I am financially responsible to pay the facility any charges incurred by the patient and promise to pay the facility promptly the amount of such charges which are not paid by any insurance carrier for any reason. I agree that in the event my account should become delinquent, I will pay all reasonable attorney fees, court costs, and other expenses pertaining to the collection of such account whether or not a lawsuit is commenced in connection with such collection efforts. I understand that any medical insurance payment sent to me directly for services rendered at the facility indicated herein must be turned over to Urology Surgery Center Northwest.
7. **No Surprise Billing:**
   I understand that I have certain protections against surprise medical bills and balance billing.
   This has been explained to me. If you believe you have been wrongly billed, please call the Business Office Coordinator, at 509-245-6858 or via email at ascadmin@spokaneurology.com.
   Additionally, you may call the federal agencies responsible for enforcing the federal balance billing protection law at 1-800-985-3059
   Visit cms.gov/no surprises for more information about your rights under federal law
8. **Anesthesia Financially Responsible:**
   I acknowledge that I am financially responsible for all charges for services rendered to me by the anesthesia provider as assigned by Urology Surgery Center Northwest and that I am responsible for

payment of any and all charges that are not paid by my health insurance. Fees for anesthesia services are separate from the facility fee and those of your surgeon. I hereby assign and authorize any and all insurance payments including Medicare and Medicaid to be made directly to the anesthesia provider's practice for any services provided to me by their staff during the encounter. If I received a bill from the anesthesia department and I have questions, I will contact OnShore billing at 509-289-4432.

9. **Lab and Pathology Responsibility:**
   I understand that lab services and pathology are outsourced I acknowledge that I am financially responsible for all charges for services rendered to me by the outsourced lab or pathology as assigned by Urology Surgery Center Northwest and that I am responsible for payment of any and all charges that are not paid by my health insurance. I hereby assign and authorize any and all insurance payments including Medicare and Medicaid to be made directly to the lab or pathology office for any services provided to me.
10. **Authorization For Release of Information:**
    I authorize USCNW, its affiliates and subsidiaries to release medical information concerning the procedure(s) performed by USCNW as may be requested by third party payors in order to process payment of my claim.

I certify that I have read this Financial Policy, that the information given is correct and I have access to a copy of it. I understand that no employee at USCNW is authorized to change or eliminate any provision of this Agreement. No alterations, additions or deletions shall change the obligation to which I have agreed.