URGI-MED FAMILY MEDICAL CENTER
FAMILY MEDICINE WITH DEDICATION AND COMPASSION
400 RT 10 WEST RANDOLPH, NJ 07869
TEL: 973-891-1321 **FAX**: 973-206-5049

INSURANCE/PAYMENT POLICY

URGI-MED will submit claims to certain insurance companies for services rendered. Our office makes no representation that we participate with your particular insurance plan. If you have any questions regarding details and/or restrictions of your plan, you must contact your insurance carrier directly. Outlined below are our practice's policies with regard to payment for services rendered.

- All co-payments are due at time of service. Although we may participate with your insurance carrier, we may not participate with your particular plan.
- If you are here for a motor vehicle accident and your auto insurance is your primary insurance, you must pay in full at the time of service.
- If a claim is submitted on your behalf, you will be balance-billed for all non-covered services, co-insurance and deductibles.
- Payment is due within fifteen (15) days of receipt of a bill.
- Balances not paid within fifteen (15) days will be subject to a $7.00 rebilling charge and any additional costs associated with collections. Additional collections costs can include: Certified Letter fee of $10.00; Court Preparation fee of $6.00; Court Service fee of $22.00 and fees from a Third Party Collection Service (may be up to 50%) as assessed by said company. Customary attorney fees and interest charges will be added to your bill if your account is sent to collections.
- A fee of $26.00 will be assessed for all returned checks.
- A fee may be assessed for copies of medical records.
- A fee of $25 may be assessed for any appointment not cancelled within 24 hours.

It is the patient's responsibility to obtain referrals in advance of scheduling appointments with specialists if their plan requires one. Requests for referrals will be reviewed by a physician and the patient will be notified within five (5) days of the status of the request. URGI-MED is not permitted to issue back-dated referrals.

I hereby authorize my insurance carrier to release payment directly to URGI-MED for medical services provided to me. I also authorize release of any medical records or information required to determine benefits for payment of medical services.

SIGNATURE:_____

DATE:_____

PRINT NAME:_____