# Arkansas Urology-Financial Policy
## Effective: August 1, 2025
## Revised: October 17,2025

**Purpose**

This policy outlines the procedures for billing, insurance, and payment processing at our office. We want you to understand your financial responsibilities so we can focus on providing you with excellent care.

### Insurance and Identification Requirements

- A valid photo ID and current insurance card must be presented at each visit.
- Notify the office of any changes in insurance, address, or personal information.

**Payment Expectations**

- Co-pays, deductibles, co-insurance, and outstanding balances are due at the time of service.
- We accept cash, checks, credit/debit cards, CareCredit, and money orders.

**Prior Authorization**

- You are responsible for obtaining referrals or pre-authorizations when required by your insurance plan.
- Failure to obtain authorization may result in denial of coverage and full patient responsibility.

**Pre-Service Deposits & Surgery Cost Estimates**

- In most cases, our office will provide a good-faith cost estimate and pre-collect your estimated financial responsibility within seven days prior to scheduled procedure/surgery. (i.e. radiology, injections, etc.) A patient representative will contact you to discuss your plan benefits, estimated costs, and collect your pre-service deposit prior to your scheduled procedure at Arkansas Urology.
- For any scheduled surgery at the Centerview Surgery Center, a cost estimate will be provided prior to the scheduled surgery.
- Surgery may be rescheduled or cancelled if payment is not received.
- For your convenience, our office accepts cash, checks, money orders, care credit and debit/credit cards. Personal checks **will not** be accepted for Surgery deposits. Payment plans are available in limited circumstances.

**Elective and Non-Covered Services**

- You may be required to pre-pay for services that are elective or not covered by your insurance plan.
- We will refund any money due to you if the insurance company pays for the service.
- Certain elective services require advance payment and will not be filed with the insurance.

**Third-Party Services**

- Some services, like lab work, anesthesia, or radiology, may be billed separately.
- Anesthesia services are billed by Professional Consulting 501-771-4693.
- Radiology services are billed by Practice Plus 501-812-7587.
- Arkansas Urology contracts with multiple companies for molecular testing, as well as other laboratory procedures. Some insurance plans may cover these services as out-of-network benefits, while others may not.

- Contact your insurance company to determine how these services will be paid under your policy before you come for your appointment.

**Non-Covered Services & Out of Network Care**

- Services deemed non-covered or out-of-network by insurance are your responsibility.
- You should verify coverage and preauthorization requirements before procedures.

**Billing and Claims**

- We will submit claims to your primary insurance as a courtesy.
- Please disclose all insurance information, including primary and secondary insurance, as well as any change of insurance information.
- You are responsible for any balance not covered by insurance, including denied claims, uncovered services, and late filing issues.
- Although we may estimate what your insurance company may pay, the final determination of your eligibility and benefits is made by the insurance company.
- If your insurance company is not contracted with us, you agree to pay any portion of the charges not covered by insurance, including but not limited to those charges above the usual and customary allowance.

**Outstanding Balance Policy**

- Pay your bill when you receive it.
- If unpaid after **90 days**, your account may go to collections, and you may be discharged from our practice.
- You may also be responsible for **collection or legal fees**.
- Payment plans are available. Please contact our Billing Office at (501)-246-3423 for further information.

**Missed Appointments**

- Please cancel at least **24 hours in advance**.
- There is a no-show fee associated with appointments that are **not** cancelled **24 hours** in advance. **$50** for office visits and **$100** for office surgeries/Procedures
- Repeated no-shows may result in your dismissal from the practice.

**Self-Pay Accounts**

- You are considered self-pay if you do not have active insurance coverage or if a valid insurance card is not on file at the time of service.
- It is your responsibility to verify whether our office participates in your insurance plan.
- Workers' compensation and automobile accident cases are treated as self-pay unless prior arrangements have been made and verified.
- If there is any discrepancy in the insurance information provided, the account will be classified as self-pay until accurate and complete documentation is received.
- Self-paying patients are expected to pay according to a Good Faith Estimate for the scheduled services that day. Good faith estimates are given prior to appointments ( No surprise billing)

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**Minors**

- Parents or guardians are responsible for payment for minors.
- The adult who brings the child is responsible for payment at the time of service.
- In cases of shared custody, the parent who brings the child for treatment will be held financially responsible at the time of service, regardless of any court-ordered financial arrangements.

**FMLA, Disability, and Other Forms**

- There is a **$40 fee** for completing these forms, payable in advance.

**Returned Checks**

- A **$25 fee** will be charged for any returned check.
- This fee will be added to your balance.
- Future payments may need to be made by **cash, money order, credit/debit card or care credit**.

**Contact Information**

For billing questions or financial counseling, please contact **the Financial Specialist at (501)219-8998**

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**Patient Acknowledgment of Financial Policy**

By signing, you agree to this policy and authorize:

- Your insurance to pay Arkansas Urology directly.
- Arkansas Urology to share necessary medical info with your insurance.
- Third-party billing services to contact you if needed.

Signature: _____ Date: _____

Relationship to patient/Name: _____