

Michael C. Solomon MD PA FACS
Board Certified Urologist
Adult and Pediatric

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Financial Policy

Thank you for choosing Michael C. Solomon MD PA as your health care provider. We are committed to providing you with the best care possible. Please understand that payment of your bill is considered part of your treatment. If you have medical insurance we are eager to help you receive your maximum allowable benefits. The following is a statement of our financial policy, which we require you to read and sign prior to any treatment. All patients must complete all required paperwork before seeing the doctor.

PAYMENT IS DUE AT THE TIME OF SERVICE. WE ACCEPT CASH, CHECKS OR CREDIT CARDS. Payments are required to be paid at the time of service. Pre-payment options are available and are encouraged in order to avoid any additional charges. *Patients will be responsible for any fees incurred from collection agencies and/or legal services hired by Michael C. Solomon MD PA to secure payment for services.*

Returned Checks: There will be a \$25.00 charge for all returned checks.

Insurance: We file all claims with your insurance company as a courtesy. However, we do require the patient's percentage of the bill to be paid at the time of service. We cannot bill your insurance company unless we have a current copy of your insurance card. Your insurance policy is a contract between you and your insurance company. If your insurance company has not paid your account in full within 45 days, you will be responsible for the bill within 10 days of receipt of your statement. Please be aware that some, and perhaps all, of the services provided may be NON-COVERED SERVICES and not considered reasonable by your insurance policy, and payment of such services will be the patient's responsibility. It is your responsibility to notify us of any changes in your insurance status or insurance company, i.e. claims office address. Please note that should there be any delay in notification of any change in your insurance information, you will be responsible for full payment of service for that visit.

Non-Contracted or Out of Network Plans: Plans with which Dr. Solomon is not contracted with may require payment in full at the time of service, unless an alternate financial arrangement has been made with our billing office prior to the service.

Co-Pays: All applicable co-pays are due at the time of service.

Self Pay Patients: Full payment is due at the time of service unless a prior alternate financial arrangement has been made with our billing office.

Medicare Patients: Michael C. Solomon MD PA does participate in Medicare and therefore we accept assignment for services. Medicare pays 80% of what they approve and you are responsible for the remaining 20% coinsurance as well as any deductibles and non-covered services. If you have secondary insurance, which may cover this 20%, please submit a copy of the card at the time of your appointment so that we may file a claim for you.

Medicaid Patients: At this time we are no longer accepting Medicaid / Medipass / Medicaid Share-of-Cost as primary insurance. Medicare patients who have Medicaid as a secondary will be responsible for a \$2.00 co-pay at the time of services.

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No Show/Cancellation Policy: There may be a fee for no-show appointments or cancellation of appointments without a 24-hour notice.

Managed Care & Referrals: Patients are responsible for ensuring that they are seeing a physician listed in their Provider Directory. Failure to do so would result in the patient being responsible for charges incurred. It is not the responsibility of Michael C. Solomon, MD PA to ensure that we are providers. Our main concern is the health of our patients. Patients that are members of an HMO are required to secure a referral from their Primary Care Physician (PCP) before scheduling an appointment with a specialist. If the referral is not secured by our office the day prior to follow up visits, the patient will be notified and will be given the following options:

1. Reschedule Appointment
2. Keep appointment & pay for services
3. Secure referral from PCP and bring to appointment.

Our office will inform you when a new referral is needed. To expedite the referral process patients are encouraged to inform their PCP office of all follow up appointments, procedures, and/or surgeries.

Account Statements: Statements are mailed out monthly to patients who may have a balance due on their account. Payment of this balance is expected on receipt of the statement. Any payment plans must be arranged with our billing department. Seriously passed due accounts may be referred to a collection agency. ***Patients will be responsible for any fees incurred from collection agencies and/or legal services hired by Michael C. Solomon MD PA to secure payment for services.***

BENEFIT ASSIGNMENT / RELEASE OF INFORMATION / MEDIGAP

I, hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled to Michael C. Solomon, MD PA. THIS IS A DIRECT ASSIGNMENT OF MY BENEFITS UNDER THIS POLICY.

A photocopy of my insurance card is to be considered as the valid original. I, hereby authorize Michael C. Solomon, MD PA to release all information necessary, including medical records and HIV related medical record documentation, if any, to any third party payer whom the patient has directed the bill be sent to secure payment. My signature constitutes a lifetime authorization. I authorize the doctor to initiate a complaint to the Insurance Commissioner on my behalf.

_____ I prefer that Michael C. Solomon, MD PA contact me before any HIV related medical record documentation be given to any party including my insurance company. In which case I will be responsible for charges incurred from your office within 10 days after contacting me. I do understand that information regarding HIV results, therapy, counseling, etc., obtained by Michael C. Solomon MD PA will be released to the Health Department as required by law. I request that

I request that payment of authorized **MEDIGAP** benefits be made either to me or on my behalf to Michael C. Solomon MD PA for any services furnished to me by that physician. I authorize any holder of medical information about me release to my insurance company any information needed to determine these benefits or the benefits of related services. My signature constitutes as a lifetime authorization.

Name of Patient (printed) _____

Signature of Patient _____ Today's Date _____

Signature of Guardian _____ Today's Date _____
(If applicable)