

## Financial Policy

Complete insurance information is required in order for our office to file a claim with your insurance company. If this information is not provided at the time of your first visit, we will require payment in full.

- **HMO/PPO Insurance Plans**  
We will file all claims for HMO and PPO patients. We do request payment of any **co-pay/remaining deductible** at the time of your visit. We must have your insurance card, billing information and current **Photo ID / Driver's License**. This will be required at the time of your first visit. You will receive a statement after your insurance pays, identifying portions defined by your insurance to be your responsibility.
- **Individuals without medical insurance**  
**For individuals without insurance, payment must be made in full at the time of service for the initial appointment. Payment arrangements will be made available for services provided after the preliminary visit. For questions or payments, our billing department can be reached at 303.247.1968.**
- **Medicare/Secondary Insurance**  
**Alpine Urology, P.C. participates with Medicare. We file all primary insurance claims and will file your secondary insurance providing we have a current and accurate copy of your insurance information.**
- **Injury related claims (Workers' Comp, Auto, Personal Injury)**  
We file workers' comp, auto and personal injury claims on your behalf. You must have a valid workers' compensation/auto claim number in order for us to file a claim. If you do not have **APPROVAL** at the time of your visit, you will be rescheduled for a later date.
- **Non-Participating provider with Medicaid of Colorado**  
Alpine Urology, P.C. does not participate with the Colorado Medicaid Program. By signing below, the patient understands that he/she will be financially responsible for any charges that occur.
- **Lab work will be sent to your insurance contracted lab.**

### FINANCIAL STATEMENT

Patient hereby acknowledges and agrees that any account that becomes delinquent will be subject to collections service. Patient agrees to pay all court costs and reasonable attorney fees for collection of all past due amounts owed, plus any interest that accrue.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

### ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I received Alpine Urology's Notice of Privacy Practices.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_