



Bradley W. Rupp, M.D.

631 SW Horne Street, Suite 150 ~ Topeka, KS 66606

Telephone: (785) 354-RUPP (7877) ~ General Fax: (785) 354-7878

Medical Information Electronic Fax: (785) 235-1008

Patient Financial Policy

Thank you for choosing Rupp Urology Clinic as your health care provider. We are committed to building a successful physician-patient relationship with you and your family. Your clear understanding of our Patient Financial Policy is important to our professional relationship. Please understand that payment for services is a part of that relationship. Please ask if you have any questions about our fees, our policies, or your responsibilities. It is your responsibility to notify our office of any patient information changes (i.e. address, phone number, name, insurance information, etc.).

METHODS OF PAYMENT

We accept the following methods of payment:

- Cash, Check, Money Order, Credit Cards (Visa, MasterCard, Discover)
- HSA and HRA debit cards

CO-PAYMENTS/BALANCES

The patient is expected to present ID and current insurance card **at each visit**. All co-payments and past due balances are due at the time of check-in unless previous arrangements have been made with the office. We accept cash, check, money order or credit cards. Absolutely no post dated checks will be accepted.

INSURANCE CLAIMS

Insurance is a contract between you and your insurance company. In most cases, we are NOT a party of this contract. We will bill your primary insurance company and any secondary insurance as a courtesy to you. In order to properly bill your insurance company, we require that you disclose all insurance information, including primary and secondary insurance plans, as well as any change of insurance information. Failure to provide complete insurance information may result in the patient responsibility for the entire bill. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. 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 allowances. If we are out of network for your insurance company and your insurance pays you directly, you are responsible for payment and agree to forward the payment to us immediately.

REFERRALS/AUTHORIZATION

If your insurance company requires a referral, you are responsible for obtaining this document. Failure to obtain the referral may result in a lower payment or no payment from the insurance company and the balance will be your responsibility.

LABORATORY SERVICES

If you need testing to be sent out to a specific lab, you are responsible to notify the staff each time a test is ordered. In the event you receive a bill that you feel should have been paid by your insurance, contact our office for assistance.



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SELF-PAY ACCOUNTS

Self-pay accounts are patients without insurance coverage, patients covered by insurance plans in which the office does not participate, or patients without an insurance card on file with us. It is always the patient's responsibility to know if our office is participating in their plan. If there is a discrepancy with our information, the patient will be considered self-pay until otherwise proven. Extended payment arrangements are available if needed. Please ask to speak with the billing office to discuss a mutually agreeable payment plan. It is never our intention to cause hardship to our patients, only to provide them with the best care possible and the least amount of stress.

Payment in full is expected at time of service. Patient is offered a 10% discount if paying full amount due. If patient cannot pay in full the discount is forfeited and patient is offered \$100.00 deposit to be paid at time of check-in and/or prior to seeing the doctor. This amount will be applied toward the charges for the services provided.

After seeing the doctor and upon check-out, you will be required to pay for any additional amounts due for services rendered which could include but are not limited to: *Lab Tests, X-rays, CT Scans, Office Procedures, Office Visit/Consult.*

Cysto/Stent Removal: Payment in full is expected at time of service. Patient is offered a 10% discount if paying full amount due. If patient cannot pay in full the discount is forfeited and patient is offered \$300.00 deposit to be paid at the time of check-in and/or prior to seeing the doctor. This amount will be applied to the services provided.

VASECTOMY PRE-PAYMENT

In the event vasectomy is not a covered benefit with your insurance plan and/or you do not have insurance, **pre-payment is required. Full payment is expected prior to the procedure.** We will contact your insurance to get the out of pocket expense and/or deductible which will be due at time of service. If full payment is not received, the vasectomy procedure will be canceled/rescheduled until payment is received.

WORKERS COMENSATION AND AUTOMOBILE ACCIDENTS

In the case of a worker's compensation injury or automobile accident, it is your responsibility to obtain the **claim number, phone number, contact person, and name and address of the insurance carrier** prior to your visit. If this information is not provided, you will be asked to either reschedule your appointment or pay for your visit at the time of service.

OUTSTANDING BALANCE POLICY

It is our policy that all past due accounts must be paid prior to making an appointment. If you are not able to pay the balance in full, we will work with you to arrange a reasonable payment plan. If no resolution can be made, your account may be sent to the collection agency and possible discharge from the practice.

This financial policy help the office provide quality care to our valued patients. If you have any questions or need clarification of any of the above policies, please feel free to contact us at (785) 354-7877.