

Swedish Urology Group, P.C.
1101 Madison St., #1400
Seattle, WA 98104
206-386-6266

Financial Policy Statement

Thank you for choosing Swedish Urology Group as your healthcare provider. We are committed to providing you the best possible medical care. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy that we require you to read and sign prior to any treatment.

We will submit your bill to your insurance company if we are a contracted provider. You must present a valid insurance card at the time of your visit or we will assume that you are responsible for payment in full at the time of service. All co-pays and deductibles are due prior to treatment.

If we are not billing your insurance, full payment for professional services is due at the time of service. We accept cash, Visa and Mastercard.

There are many insurance plans with which we have no contractual agreement. We are happy to assist you to receive your maximum allowable benefits and will file the claim for you upon request. **You remain responsible for payment of services.** Your insurance policy is a contract between you and your insurance company. Please note that credit balances of \$10.00 or less are refunded upon request. Otherwise, the credit will remain on your account until your next visit.

Our staff is trained to help you with any insurance question you may have. We can answer your questions relating specifically to our charges and your claim. **COVERAGE ISSUES** can only be addressed by your employer, group plan administrator or the member services department of your insurance carrier.

If you have any questions about our financial policy, please feel free to talk with someone in our business office. You may call 206-224-7286 or stop in to see us while here for your appointment.

Your payment method selection and signature below indicate you have read this policy and understand its contents.

Payment today will be made by: Check Cash Credit Card

I have a contracted insurance carrier and will pay my co-pay or deductible today.

Responsible Party (or Patient) Signature

Please note that any charges we incur in an effort to collect payment on your account will be added to your balance (bank and collection agency charges, as examples, along with an administrative charge of \$25.00)