



## OUR OFFICE POLICIES

It is our philosophy at **Turnure Medical Group** that our relationship with you is built upon mutual trust and open communication. We value you as a patient; therefore, it is in your **best interest** that we disclose this information to you.

### INSURANCE & PAYMENT POLICY FOR SERVICES

Unless prior arrangements have been made we request full payment at time of service. If we are contracted with your insurance, as a courtesy we will submit your charges for reimbursement. Your copayment will be collected and if you have a deductible please be prepared to make a "good faith" estimated deposit on your account until your deductible has been satisfied. After billing your insurance you will be responsible for any additional co-insurance or services that were not covered. We recommend that you **KNOW YOUR PLAN** and what you are covered for as most plans do not cover everything at 100%. You will also be responsible for any charges that your insurance does not pay in a timely matter or if your insurance company were to become insolvent. We cannot, as a third party, become involved in prolonged insurance negotiations as this is a contract between you and your insurance company. If your check is dishonored by your bank your account will be assessed a \$25 non-sufficient funds fee. Any accounts past due over 30 days will be assessed a late fee of \$15 per month. At times it may be necessary for us to file a complaint against your insurance company or Labor Union. My signature below indicates that I have given **Turnure Medical Group** authorization to file a complaint with the Department of Insurance/Managed Care or the Labor Board on my behalf.

**HMO PLANS**-Dr. Couillard (Urology) is the **only** physician in our group that has an HMO contract with Sutter Medical Group. All HMO plans require **PRIOR AUTHORIZATION** from your primary care physician. **IT IS YOUR RESPONSIBILITY TO OBTAIN THE PRIOR AUTHORIZATION** prior to your visit. If you are seen without Prior Authorization you will owe the entire amount for your visit. There are no exceptions as Sutter Medical Group will **NOT** back date Prior Authorizations.

### AUTHORIZATION RELEASE

I authorize **Turnure Medical Group** to release any medical information including diagnosis, x-rays, test results, reports and records pertaining to any treatment or examination rendered to me. I understand that this medical information may be used for diagnostic, insurance, legal and research at times when my physician deems it necessary in order to ensure the best medical care on my behalf. I further understand that any person(s) that receives these medical records will not release any medical information obtained by this authorization to any other person or organization without further authorization signed by me for release of information. This office protects patient's information in accordance with the Health Insurance Portability & Accountability Act (HIPAA). My signature below indicates my authorization and acknowledges that I have received information on our Office Privacy Practices.

Print name: \_\_\_\_\_

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Patient, Parent/Guardian or Power of Attorney