

## **Financial Policy**

Thank you for choosing KU Wichita Medical Practice Association for your medical care. We appreciate that you have entrusted us with your health care, and we are committed to providing you with the best patient care possible. Because healthcare benefits and coverage options have become increasingly complex, we have developed this financial policy to help you better understand your rights and responsibilities as a patient.

### **Insurance Coverage**

For the convenience of the patient, we will file claims with your insurance plan, if valid insurance information is provided to us. It is the responsibility of the patient to make accurate and detailed insurance information available to us to enable processing of claims. The patient is considered self-pay without valid insurance information.

The patient is responsible for notifying our office of any insurance changes. Insurance policies are an agreement between the patient and his or her insurance company. The patient is expected to know his or her insurance benefits to include deductible and co-payments.

### **Referrals/Authorizations**

It is the responsibility of the patient to obtain a referral from his or her primary care physician prior to the scheduled visit. If a referral is not obtained, the patient accepts full financial responsibility for all services rendered.

### **Address/Phone Number Changes**

It is important that we have your correct address and telephone information on file. Please notify us anytime there is a change to your address, telephone, or contact information. Failure to update our office of changes will delay the billing process for your account.

### **No Surprises Act/Good Faith Estimate**

KU Wichita MPA will produce a “*Good Faith Estimate*” at the time of visit if requested by the self-pay patient. Good Faith Estimate provides a quote for the cost of treatment before services are performed. Patient may authorize the provider to proceed or halt treatment based upon their current financial situation. Additional details of the No Surprises Act can be provided to the patient upon request.

### **Self-Pay**

Self-Pay patients are patients without insurance coverage. If you do not have insurance coverage you are eligible for a 35% discount on services. Payment is due at the time services are rendered.

### **Copay**

Copays are due at the time of service. If your unable to pay your copay, please call to reschedule your appointment to a date that is convenient for you.

### **Billing Department**

1010 N Kansas, Suite 3049 | Wichita, KS 67214-3199 | (316) 293-3429 | Fax (316) 293-1882

**Outstanding Balances**

If you are unable to pay your balance in full, our billing office can set you up on a payment plan. To continue to be treated by our office we require a payment arrangement in place and monthly payments made on your account. If your account becomes delinquent it could be turned over to a collection agency. Unpaid balances may result in dismissal from the practice.

**Payments**

We will bill your insurance for medical services. Once they have paid, if there is a balance due from any remaining deductible or co-insurance you will receive a statement. If you are unable to pay the full balance due on your statement, please contact our billing office at 316-293-3429.

**Minors**

For patients under the age of 18, a parent or guardian is responsible for payment.

**Assignment of Benefits**

I do hereby authorize the release of any medical information necessary to process claims on my behalf. I request that all insurance benefits be paid directly to UKSM-W Medical Practice Association for all charges incurred by me. I understand that I am responsible for all charges incurred during my treat at UKSM-W Medical Practice Association Clinics regardless of insurance coverage. I agree to pay the entire balance of my account in a timely manner.

I understand the KU Wichita MPA Financial Policy and will adhere to the policy.

\_\_\_\_\_  
Signature of Patient or Responsible Party

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Patient or Responsible Party

\_\_\_\_\_  
Relationship to Patient

We look forward to providing you with quality care. If you have any additional questions or concerns, please contact our billing office at 316-293-3429.