

THE CENTER FOR MEN'S AND WOMEN'S UROLOGY

FINANCIAL POLICY

It is our office policy to inform you of our patient payment procedures. Please review our financial policies carefully and let us know if you have any questions or need assistance.

Please initial one:

_____ **If we are billing Insurance:**

You are responsible for deductibles, co-pays, coinsurances and non-covered services. Co-payment amounts are due at time of service. If your insurance plan includes a deductible, and that deductible is **NOT** satisfied, you may be required to pay the deductible deposit at time of service. The deductible deposits are assessed as follows: a \$200 deposit at your first visit, and/or a \$100 deposit at each subsequent visit, and/or a \$500 to \$1000 deposit for any surgeries or in-office procedures depending upon your current insurance benefits, until your deductible is satisfied. Any remaining balance will be billed to you and is due within 30 days of receiving our statement. You will be notified in advance of your appointment with the amount due at time of service **IF** one of the above deductible situations applies to you after your insurance coverage has been verified.

I understand that in the event that my insurance company does not pay for today's service, if my insurance is not in effect on this date, or if The Center for Men's and Women's Urology is not currently participating in my insurance plan, I agree to, and personally accept full financial responsibility.

_____ **If we are not billing Insurance:**

Payment for service is due at each visit. We require a \$200 payment for your first office visit, \$100 for subsequent office visits, and \$500 to \$1000 for surgeries and in-office procedures. Any remaining balance will be billed to you and is due within 30 days of receiving our statement. If you make a payment exceeding your balance, reimbursement will be remitted.

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- Please be aware, that if you are sent to an outside laboratory, imaging facility, or hospital for further testing, you will not only receive a statement from our office, but also from that outside facility.
 - We accept Visa, Master Card, American Express, personal check or cash as payment.
 - We require that you notify our office **3 working days** prior to the cancellation of an in-hospital surgery. Otherwise you may be charged a fee of \$100 for the missed procedure.
 - We require that you notify our office at least **24 hours** prior to the cancellation of all appointments. Vasectomy and Urodynamic procedures will be charged \$50; all other appointments will be charged \$25 for the missed appointment.

RELEASE OF INFORMATION

Please initial:

_____ I authorize The Center for Men's and Women's Urology to release to my insurance carrier and/or CMS (Medicare) and its agents, any information needed to determine benefits or benefits payable for related services.

_____ I authorize The Center for Men's and Women's Urology to release pertinent medical information to other physicians involved in my care, (such as my PCP) as needed.

I have read and agree to the Financial Policy stated above that apply to me.

Patient or Responsible Party Signature

Date

Print Name

Relationship to Patient (if not self)