Financial Policy for Participating Insurance Carriers

Thank you for choosing us to provide your urologic care. We are committed to the highest standards of care and the latest technologies in this rapidly advancing field of medicine. The following is a statement of our Financial Policy, which we request that you read, agree and sign prior to treatment.

All patients must complete our Information and Insurance Forms and present insurance card and valid driver's license to be photocopied prior to seeing the physician.

We accept cash, checks, Visa and MasterCard. All office visits co-payments and coinsurances are due at time of treatment. Any prior balance on your account must be paid in full.

If you should provide inaccurate insurance information that results in no payment from your correct and current insurance carrier due to timely filing limits, you will be responsible for the entire bill in full.

Please be aware that some and perhaps all of the services provided may be "non-covered" services and not considered "reasonable" or "necessary" under your insurance coverage based on your diagnosis. We will do our best to advise you in advance of this situation. Any services non-covered by your insurance carrier becomes your financial responsibility and due in full promptly.

We must charge a fee of $25.00 for appointments not cancelled or rescheduled without 24 hours notice. This fee is not payable by your insurance carrier.

The charge for cancelling or rescheduling a surgical procedure without 48 hours notice will be $250.00. This is not covered by your insurance carrier and must be paid prior to rescheduling your procedure.

This financial policy is to clarify any questions you may have about your financial obligation. If the amount becomes delinquent the doctor, his assigns or lawful agents may pursue collection procedures. You will be responsible for all collection costs, including but not limited to standard collection costs, court filing fees, service of process costs, interest and attorney fees.

Thank you for understanding our Financial Policy. If you should have any questions please ask before services are rendered. I have read, understood and agree to the provisions of this Financial Policy.

Signature of Responsible Party Date Signature of Co-Responsible Party Date

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ASSIGNMENT OF BENEFITS

I authorize LaPlata Urology Center to request and receive information regarding my insurance coverage and benefits. Also to apply for benefits on my behalf for services rendered to me and request payment from my insurance company to made directly to LaPlata Urology Center. A copy of this authorization may be used in place of the original.

Signed : Date:

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