CHILDREN'S UROLOGY

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PATIENT FINANCIAL POLICY SHEET

To reduce confusion and misunderstanding between our patients and practice, we have adopted the following financial policies. If you have any questions regarding these policies, please discuss them with our Billing Manager. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

PAYMENT IS DUE IN FULL AT THE TIME OF SERVICE unless other arrangements have been made in advance by either you or your health insurance carrier. For your convenience we accept VISA, MasterCard, Discover, cash and checks.

YOUR INSURANCE (PLEASE INITIAL)

___ _ We apologize in advance, but **test results** will not be discussed over the phone.

___ _ We have made prior arrangements with many insurers and health plans to accept an assignment of benefits. This means that we will bill those plans for which we have an agreement and will only require you to pay the authorized co-payment, deductible and/or co-insurance at the time of service. **This office's policy is to collect this co-payment when you arrive for your appointment.**

___ _ It is the responsibility of the guarantor to know the benefits associated with their insurance plan or coverage and to obtain all referrals and authorizations from the primary care physician, when applicable. **IF YOU DO NOT HAVE A CURRENT REFERRAL OR AUTHORIZATION ON FILE, YOU MAY BE ASKED TO RESCHEDULE YOUR APPOINTMENT.**

___ _ If the child has secondary insurance this information must be given to our office on the date of services. We will not accept the secondary insurance after this date.

___ _ It is the guarantor's responsibility to know where their insurance company **REQUIRES THEM TO OBTAIN ANY LABS, X-RAYS, AND ANY OTHER ANCILLARY SERVICES**. Please let your doctor's medical assistant or nurse now so that they may schedule things accordingly.

___ _ Surgery deposits are due 5 business days prior to surgery. If for any reason surgery needs to be canceled it must be done 10 business days prior to the surgery date or a **$100.00 cancelation fee** may be charged to the parents.

___ _ In the event that your health plan determines a service to be "not covered," you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.

___ _ If we do NOT participate with your insurance company, you will be considered a self-pay patient. The protocol for self-pay patients, as seen below, will apply. As a courtesy, we can submit a claim to your insurance company on your behalf, and your insurance company can reimburse you.

SELF-PAY PATIENTS

___ _ If you do not have insurance you will be considered a self pay patient, which means that upon arrival before seeing the doctor you will need to make a deposit of **$100.00**. If the ENTIRE account is paid in FULL we will apply a 25% discount to your account. Please note that if you are unable to pay the entire account in full you will not receive the 25% discount. You will also need to make payment arrangements at CHECK-OUT to pay the balance in full within **3 months**.

WE ACCEPT VISA, MASTERCARD, DISCOVER, CASH AND CHECKS.

MINOR PATIENTS

For all services rendered to minor patients, we will look to the adult accompanying the patient and the parent or guardian with custody for payment.

MINOR PATIENT NAME: _____

In case a parent is not able to accompany the child, please list names of individuals you are allowing to accompany and make possible medical decisions for the minor patient listed below:

NAME: _____

RELATIONSHIP: _____

NAME: _____

RELATIONSHIP: _____

FEES

___ _ **FEE FOR FORMS COMPLETION:** I understand that I will be responsible for paying **$25.00** for forms completed by my physician or staff. (Example: Disability forms, FMLA forms, etc.) **$50.00** fee for Immigration forms/letters.

___ _ **FEE FOR "NO SHOW":** I understand that a **$25.00** "no show" fee may be assessed for any appointments that I do not keep.

I have read and understand the financial policy of the practice, and I agree to be bound by its terms. I also understand and agree that the practice may amend such terms from time to time.

PRINTED NAME OF THE PATIENT _____

SIGNATURE OF PATIENT
OR RESPONSIBLE PARTY IF A MINOR _____ DATE _____