

Advanced Urology, PC
Office Policies – Please Read Carefully and Sign

FINANCIAL RESPONSIBILITY

Self Pay Patients: By signing this form, you confirm your understanding that all charges incurred by reason of the treatment provided by Advanced Urology, PC are your responsibility and **MUST** be paid at the time of service.

Insured Patients: In the event that your insurance company is accepted by our practice, we will only accept payment from your carrier once all copays and deductibles are met.

Your Responsibility:

- Ensuring that correct insurance information is provided at time of service.
- Ensuring that referrals are provided at time of service, if required by your plan.
- Providing the most recent insurance card.

I acknowledge that if I do not meet the above responsibilities, that I will be charged for all fees incurred and/or my appointment may be rescheduled.

MISSED APPOINTMENTS

A scheduled appointment means that this time is reserved only for you. We request that if you cannot make your appointment that you give us advanced notice within 24-hours. As a courtesy, we will remind you of your appointment the day before it is scheduled. If an appointment is missed without giving the office notice, a \$50.00 charge will be billed to your account. This is an administrative fee, not a charge that will be billed or paid by your insurance carrier. Future appointments will not be made until this balance is settled.

PRIVACY PRACTICES ACKNOWLEDGEMENT

My signature confirms the fact that I have been provided an opportunity to review the enclosed Notice of Privacy Practices and the above policies for Advanced Urology regarding my financial responsibility and missed appointments.

Name: _____ **Date:** _____

Signature: _____