Pediatric Urology Associates, P.C.

FINANCIAL POLICY/SIGNATURE ON FILE

Pediatric Urology Associates (PUA) is committed to providing you with the best possible care and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy/Signature on File is important to our professional relationship. Please ask if you have any questions about our fees or your financial responsibility.

**** A copy of your insurance card(s) will be made for your file ****

Co-Payments/Deductibles –We will collect your carrier designated copay and/or deductible at the time of service. Please be prepared to pay at each visit. In the case of surgery, if your plan requires a deductible, it must be paid prior to the surgery date.

Participating Insurances – For in network services we will accept the designated fee. You are responsible for any deductible or coinsurance your plan indicates on their EOB, including the full balance charged due to termination of coverage. You will be responsible for "non-covered" services as deemed by your carrier.

****NOTE: Some carriers may require that you notify them of your visit with us. Please assure to contact them to avoid additional financial responsibility ****

Referrals – If your plan requires a referral, it is YOUR responsibility to obtain it prior to the visit and have it with you on the day of service. If you do not have a valid referral with you or on file with us, you will be required to RESCHEDULE YOUR APPOINTMENT.

Out of Network Insurances (Office Visits) - You are responsible for 100% of the charge and payment is expected on the day of service. If an unanticipated test/exam is performed during the visit, we will allow 45 days for payment for the test/exam only. You will be responsible for payment of 100% of the charged amount. We will submit a claim to your carrier on your behalf.

Out of Network Insurances (Surgery) – You are responsible for paying your out of network deductible, if applicable prior to your scheduled surgery date. Once a claim is processed, you will remit the payment from the carrier and PUA will require an additional 5% payment, from you, based on the "allowed amount". If payment is not received within 45 days from the date of service, you will be responsible for 100% of the charges as billed on your statement.

Self Pay Patients (No Insurance) –You are responsible for payment on the day of service.

**** Account Balances – You are responsible for timely payment of your account. Pediatric Urology Associates reserves the right to reschedule or deny a future appointment on delinquent accounts ****

SIGNATURE ON FILE

By signing this statement, you are authorizing Pediatric Urology Associates to complete any necessary insurance claim forms on your behalf. You are hereby authorizing the release of any medical/other information which may be needed in order to process said claim(s).
Your signature will be kept on file and shall be referred to when insurance claim forms are submitted for healthcare services you have received.

NAME OF PATIENT: _____ ***NAME OF LEGAL GUARDIAN:*** _____

SIGNATURE: _____

PRINT NAME: _____ ***DATE:*** _____

I understand and agree to the above terms. I further acknowledge that in the event my account remains past due and is referred to a collection agency/law firm due to termination of coverage or additional financial responsibility deemed by my carrier, I agree to authorize said entities to communicate with my insurance company regarding my past due account and further authorize said entities to obtain and review my credit report.

WE ACCEPT CASH, CHECKS, MASTERCARD, VISA, DISCOVER AND AMERICAN EXPRESS

_____ _____

(Guardian/Responsible Party Signature) **(Date)**