

FINANCIAL POLICY

WELCOME TO THE UROLOGY CENTER. To assist you in understanding your financial responsibility to our practice, we ask that you read the following statements. Please sign the bottom acknowledging your understanding of this information.

INSURANCE BILLING – As a courtesy to you, our office will bill your insurance company. Please be sure to bring your current insurance identification to each visit.

If your insurance requires a referral and/or authorization, please determine that they are active prior to your visit. Failure to acquire necessary referral and/or authorization may delay, or necessitate a postponement of your appointment.

If we do not participate with your insurance plan, we ask that the fees for your services be paid, in full, at the conclusion of each visit. If you provide us with your insurance information, we will gladly submit your claims directly to them to assist in your reimbursement.

We cannot tell you what services may or may not be covered by your insurance carrier. Please contact your insurance company directly regarding your medical benefits.

MEDICARE – All of your services will be submitted directly to Medicare. Please provide us with any other insurance information you may have in addition to Medicare. Please **DO NOT** send payment unless you receive a bill from us. If you have a second insurance, please allow two billing cycles before you send us payment. This will give your second insurance plan time to pay their portion of the claim.

NON COVERED SERVICES – Some of our procedures, such as those for infertility, are considered elective by most insurance companies and may not be a covered benefit. Payment is expected in full at the time of booking. We will be happy to submit any claims to your insurance carrier to assist in any reimbursements due you. If they do pay for these services you will be refunded any monies due after deductibles, co-payments and participating plan adjustments, no earlier than three months after the insurance payment has been received.

CO-PAYMENTS AND BALANCES – In order to control billing costs, we must ask that any co-payments or outstanding balance, which you have been billed for, be paid **prior to** your visit.

We will do our best to work out financial arrangements satisfactory to both you and our office. Once an arrangement is made, you/the guarantor is expected to follow that payment plan. Visa, MasterCard, personal checks and cash are accepted.

I have read, understand and agree to the provisions of this Financial Policy.

Signature (of Patient or Person Financially Responsible for this Bill)

Date

ASSIGNMENT OF BENEFITS

Financial Responsibility

I understand that insurance billing is a service provided as a courtesy and that I am at all times financially responsible to the Urology Center, P.C. (the "center") and /or its affiliated entities for any charges not covered by health care benefits. Please review the Center's Agreement for Services Rendered. It is my responsibility to notify the Center of any changes in my health care coverage. I am responsible for the entire bill or balance of the bill as determined by the Center and/or my health care insurer if the submitted claims or any part of them are denied for payment.

Assignment of Benefits

I authorize direct remittance of payment of all insurance benefits, including Medicare, if I am a Medicare beneficiary, to the Center for all covered medical services and supplies provided to me during all courses of treatment and care provided by the Center and/or its affiliated entities or otherwise at its direction. I also assign a non-exclusive right to file a lawsuit, whether under Connecticut law or the Employee Retirement Income Security Act of 1974 against my insurer for payment. I understand and agree this Assignment of Benefits will have continuing effect for so long as I am being treated or cared for by the Center or an amount remains due from my insurer arising from services provided by the Center. I further understand that this Assignment of Benefits will constitute a continuing authorization, maintained on file with the Center, which will authorize and allow for direct payment to the Center of all applicable and eligible insurance benefits for all subsequent and continuing treatment, services, supplies and/or provided to me by the Center.

Authorization to Release Information

I authorize the release of any medical or any other information to the Health Care Financing Administration, my insurance carrier(s), or other entity necessary to determine insurance benefits or the benefits payable for related medical services and/or supplies provided to me by the Center. A copy of this authorization will be sent to the Health Care Financing Administration, my insurance carrier(s), or the medical entity, if requested. The original authorization will be kept on file by The Urology Center, P.C.

Printed Name

Date of Birth

Social Security Number

Signature

Date of Signature

Insurance Carrier

Member ID Number

Group Number

Signature of Insured