ADVANCED UROGYNECOLOGY

FINANCIAL POLICY

The following is a statement of our financial policy which we require that you read and sign prior to any treatment. Please understand that payment of your bill is considered a part of your treatment**, and our policy requires payment of co-payments and deductibles at the time of service.** As a courtesy we will file your claim to the insurance carries for you. If there is any balance owed after all insurance companies have made their payment, we will bill you for the remaining balance. In the event that your insurance coverage changes to a plan in which we are not participating providers, or in the event there are any services considered "not covered", we will require payment in full at the time of service.

Our agreement is with you and NOT your insurance company. You have chosen your insurance coverage. Although we will assist you in submitting your claim to your carrier, you are ultimately responsible for the services you receive. Payment to our office is not contingent or dependent on your insurance carrier, and there may be instances where we require that you keep a credit card on file.

Please note that this office always verifies benefits prior to a patient being seen by the physician, as a courtesy to the patients and that ultimately, it is your responsibility to know and verify your health benefits with your insurance plan. ***Verification of benefits is not a guarantee of payment for medical services to your physician by your insurance company***.

Prior Authorizations

If you have an insurance carrier that requires prior authorization for your visits, it is your responsibility to obtain any referrals or authorizations from your primary care physician. Failure to provide authorization may result in your appointment being rescheduled or higher out of pocket expenses.

Minor Patients: Any adult (parent or guardian) accompanying a minor will be responsible for payment in full. For unaccompanied minors, nonemergency treatment will be denied unless charges have been preauthorized to a Visa/MasterCard, or payment by cash or check at time of service has been verified.

Return Checks: Return checks fees are listed below

BOUNCED CHECK FEE	$35.00

Medical Records:

Copies of records will be provided at the request of patients for a fee of $1.00 per page for the first 25 pages and $0.25 for each additional page.

Collections

Any past due balances over 90 days will be submitted to a collection agency, unless other arrangements have been made. If your account is placed with a collection agency, the patient/debtor assumes all costs of collections including but not limited to collection agency fees ($25.00 fee), court costs, interest and legal fees. Timely payment will ensure your credit rating remains unaffected.

I HAVE READ AND FULLY UNDERSTAND THE FINANCIAL POLICY. I HEREBY AGREE TO RENDER PAYMENT IN ACCORDANCE WITH THE TERMS AND CONDITION SET FORTH.

_____ _____

(SIGNATURE OF PATIENT OF RESPONSIBLE PARTY) (DATE)

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(PRINT PATIENT NAME)