EAST VALLEY
UROLOGY CENTER

**We are committed to providing the best possible medical care and patient experience to our patients. Patients knowing and understanding their financial responsibility is a key component to a positive care experience and a successful physician patient relationship.**

**Non-Covered Services:** Patients are responsible for knowing their insurance coverage and bringing their insurance cards to their appointments. Please know your insurance benefits before each visit. You will be asked to pay for any services that are not covered by your insurance plan.

**Correct Insurance Information:** You are responsible for providing us with the most correct and update information about your health insurance. It is your responsibility to notify us immediately of a change to your health insurance plan or change in insurance status. If we have incorrect insurance information, outstanding balances will be billed to you directly.

**Payment is required at the Time of Service**: You are responsible for paying deductibles, copayments, coinsurance and other out of pocket expenses at time of service. If we are unable to verify your insurance coverage, you will be asked for payment. In addition to cash payments and checks, we also accept most major credit cards. Patients who are not covered by health insurance are required to pay for the provided services at the time of service.

**Missed Appointments:** We require a 24hr notice if you cancel an appointment or surgery. If you no-show or cancel an appointment within 24hrs of the scheduled time, there is a $50.00 charge. If you no-show or cancel a surgery within 24hrs of the scheduled time, there is a $100.00 charge. If there are multiple occurrences of this behavior, the patient may be subject to discharge from the practice.

**Special Insurance Processing Requests:** The Arizona State Constitution permits insured individuals to pay directly for health care services, if they so desire. If you choose to pay for health care services, your health care provider will not submit a claim to your health plan. It is your responsibility for notifying your provider's office when you do not wish a claim to be submitted on your behalf.

**Related Facilities or Services:** EVUC Physicians may have a financial interest in where you are referred for treatment. This may include, but not limited to surgery centers, lithotripsy centers, pathology labs, oncology treatment centers, radiation facilities that perform CT and MRI scans and other medical and non-medical related entities.

**Collection Agency Fees:** When patient accounts become extremely delinquent, patients or patient guarantors agree to pay collection agency or attorney fees or not less than thirty five (35) percent. The collection agency fees will be added to the patient's outstanding balance and collected by the collection agency upon referral to the agency.

**Administrative Charges:** Patients may incur, and are responsible for, the payment of additional charges at the discretion of EVUC. The charges may include but are not limited to (subject to change at any time). • Charge for Returned Checks $25.00 • Charge for copying and distribution of patient medical records. $50.00 • Charge for forms completion, including but not limited to disability and FMLA forms. $50.00 • Charges for providing non-English speaking interpreters. Price varies based on language.

**Patient Authorizations:** By my signature below, I hereby authorize EVUC and the physicians, staff, labs, and hospitals associated with EVUC to release ALL medical and other information acquired in the course of my examination and/ or treatment to the necessary insurance companies, third party payors, and/or other physicians or healthcare entities required to participate in my care.

_____ _____

Printed Name of Patient | Printed Name of Guardian (if Applicable)

_____ _____

Signature of Patient or Guardian | Date

Waiver of Patient Authorization I do not wish to have information released and prefer to pay at the time of service and/or to be fully responsible for payment of charges and to submit claims to insurance at my discretion.

_____ _____

Signature of Patient or Guardian | Date

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