ARIZONA UROLOGY

FINANCIAL AGREEMENT

Thank you for choosing Arizona Urology. We appreciate the confidence you have shown in choosing us to provide for your health care needs and we are committed to providing you with the best possible care. Please take a minute to read and review our financial agreement. Your understanding of this agreement is important to our professional relationship. If you have any questions with regards to our financial policies, please ask to speak with our billing department.

INSURANCE: As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf however you are ultimately responsible for the verification and/or knowledge of your benefits. In order for us to file your claim, we will need complete insurance information on any/all policies you have (primary, secondary and/or tertiary) and your signed authorization enabling direct payment to our office. Acceptable insurance identification is defined as a valid insurance card or policy. Failure to provide this information in a timely manner may result in the charges being assigned to patient responsibility. If your insurance plan has changed, please call our office **immediately** to update your information. If we are not contracted with your insurance full payment is required at the time of service. If out of network coverage is available, we will bill as such.

CO-PAYMENT: Most insurance carriers require the patient to pay a co-pay for services rendered. This co-pay is expected at the time of service for EACH VISIT. Failure to pay this co-pay at the time of service will result in your appointment being rescheduled.

PATIENT RESPONSIBILITY: Before every visit for an in-office procedure, diagnostic testing and surgery, we will estimate your patient responsibility (deductible and/or co-insurance) as determined by your contract with your insurance carrier. You will be informed of any such costs **PRIOR** to your visit and we expect these payments at time of service. **Please note this is an estimate only.** Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. If your insurance denies any part of your claim, or if you or your physician elects to continue past your approved period, you will be responsible for your balance in full. **Finance charges will begin to accrue on any unpaid patient responsibility balance after 90 days old.**

REFERRALS: If your insurance policy requires a referral, you are responsible for making sure that there is a current and valid referral prior to being seen. Please contact your Primary Care Physician's office prior to your appointment to obtain your referral.

SELF PAY: The full amount of your visit is due at the time of service for EACH VISIT unless payment arrangements are made in advance. We accept all major credit cards, cash and personal checks.

DISHONORED CHECKS: A $25 service fee will be assessed on all checks returned to our office due insufficient funds. Checks not redeemed within twenty (20) days of written notice will be referred to the County Attorney's office for enforcement of the bad check laws.

CANCELLATION/NO-SHOW POLICY: We understand there may be times when you miss an appointment due to emergencies or obligations to work or family. However, we urge you to call 24 hours prior to your appointment to cancel. **There is a $25 charge for all missed and No-Show appointments.** If you No-Show for an appointment 3 times in a row, you may be discharged from the practice. We will inform your insurance carrier and you will be notified in writing, via mail, if you are discharged from our care. For all in-office

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procedures (including any diagnostic testing to be conducted in our office) we require a minimum of 3 business days notice to cancel or reschedule your appointment. **Failure to provide us with the appropriate 3 business day notice, or if you simply do not show up to your scheduled appointment, can result in a $100.00 non-refundable charge to your account.** For all scheduled surgeries we require at least five (5) business days notice to cancel or reschedule your procedure. **Failure to provide us with the appropriate 5 business day notice, or if you simply do not show up to your scheduled surgery, will result in a $250 non-refundable charge to your account.** Exceptions to the above will be applied if extenuating circumstances present.

DELINQUENT ACCOUNTS: If you fail to make any payments for which you are deemed responsible for in a timely manner, you account may be assigned to a collection agency or attorney. In that case, you will be responsible for any additional fees, including all costs of collecting moneys owed, including but not limited to court costs, collection agency and/or attorney fees.

LAB CHARGES: Please be advised that we send most urine samples left in the office to external labs for processing. We will make every effort to make sure that your specimen is sent to a lab that is contracted by your insurance however, it is your responsibility to know your medical benefits as outlined by your insurance, including knowing your insurance plan's preferred laboratory. Please be sure to inform our staff of this such that it can be notated on your chart. Failure to provide this information may result in you getting a bill from the lab. **Please note that our offices will not be liable for any such charges that you may incur.**

PATHOLOGY CHARGES: Please note that there may be external pathology charges related to your in office procedure/testing. We send all pathology specimens to an external lab along with your insurance information such that these charges will be billed to your insurance. However, you will be responsible for any and all amounts not covered by your insurer.

FMLA: FMLA is available for patients or family members with "Serious Health Conditions". Please review the Family & Medical Leave Act for definitions of "Serious Health Conditions". Completion of an FMLA form does not guarantee your request will be granted. Our office charges a $10.00 fee for completion of forms.

CONSENT FOR TREATMENT AND AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize Arizona Urology, through its appropriate personnel, to perform or have performed upon me the appropriate assessment and treatment procedures required for my care. I further authorize Arizona Urology and its affiliates, to release to appropriate agencies, any information acquired in the course of my examination and treatment.