

Florida Urology Center

Financial Policy

We are committed to providing you with the best possible care, and we would be happy to discuss our fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees or Financial Policy.

Our office requires payment in full due at the time of service, unless we participate with your insurance company, or arrangements have been made prior to the appointment. Co-payments and deductibles are always expected at the time of the service. If it should become necessary to bill you, it is our policy to add a late payment charge of 1.5% per month on all unpaid balances starting at 30 days from the date of your first bill.

Also, *please remember that your insurance policy is a contract between you and your insurance company.* You are ultimately responsible for knowing what diagnosis (es) and/or procedure(s) may or may not be considered for payment or require deductible, co-payment, etc.

MISSED APPOINTMENTS: You may be subject to a \$50 charge for missed appointments if the appointments are not canceled at least 24 hours in advance.

INSURANCE CHANGES: Please don't forget you must notify us prior to your next visit if your insurance changes or you may be responsible for payment yourself. I understand and agree that I am ultimately responsible for the balance of my account for any professional services rendered. I certify that the information I have provided is true and correct to the best of my knowledge. I will notify you of any changes in the information that I have provided.

PATIENT WITH MEDICARE COVERAGE

I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers, any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician and authorize such physician to submit a claim to Medicare.

NON-MEDICARE PATIENTS

I authorize the release of all medical information to my insurance company (ies) and request that payment of my insurance benefits be sent directly to The Florida Urology Center (unless payment in full has been made at the time of service).

TREATMENT

By signing below, I authorize treatment by The Florida Urology Center's physicians and their staff.

Signature of Patient/Guardian

Date

**Please bring your insurance cards
and picture identification to the appointment.**