# FINANCIAL POLICY

As your physician, we are committed to providing you with the best possible medical care. In order to achieve this goal, we need your assistance, and your understanding of our payment policy.

PAYMENT FOR SERVICE IS DUE AT THE TIME SERVICES ARE RENDERED.
We accept cash, personal checks, MasterCard, and Visa. Returned checks are subject to a service charge of $20.00 or 5% of the face value of the check, whichever is greater and you will lose your privilege to write checks in our office.

CANCELED APPOINTMENTS - Patients who do not cancel appointments may be discharged from the practice after the third no-show.

CONTRACTED INSURANCE COMPANIES, PPC/HMO/MANAGED CARE COVERAGE - CO-PAYMENT AND DEDUCTIBLE MUST BE PAID AT THE TIME OF SERVICE. Because we are under contract with these insurance companies, we will file your insurance. Contact your insurance company to see if we are a participating provider.

MEDICARE - Your deductible and 20% of the allowable charges are due at the time of service. Since we are a Medicare provider we will file your Medicare. If we do not know the Medicare allowable charge for a specific service, we will bill you after Medicare pays. Please bring your Medicare Explanation Of Benefits (EOB) showing you have met your deductible.

WORKERS' COMPENSATION - We will call your employer to authorize your visit prior to your appointment. We will file with your company's insurance. In the event you fail to prosecute the claim for Workers' Compensation for this illness or condition or it is determined by the Workers' Compensation board that the illness or condition is not a result of a compensable Workers' Compensation case, you agree to pay the usual and customary fees for services rendered to you in this case.

FINANCIAL AGREEMENT - We will gladly discuss your proposed treatment and do our best to answer any questions relating to your insurance. You must realize, however, that:

1. **Your insurance is a contract between you, your employer, and the insurance company. We are not party to that contract.**
2. **Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover (eg, yearly physicals).**

We must emphasize that as your medical care providers, our relationship and concern is with you and your health, not your insurance company. **ALL CHARGES ARE YOUR RESPONSIBILITY FROM THE DATE SERVICES ARE RENDERED.** On any balance on your account after 60 days, including those that insurance has not paid, collection action will be taken.

**IMPORTANT NOTICE:**

***Pinellas Urology, Inc.*** has an ongoing credit policy for our clients. Our terms are net 30 days. Late charges of 1.5% per month (18% APR) may be assessed on past-due accounts, and collection charges and/or attorney fees may be adde

If you have any questions about the above information or any uncertainty regarding insurance coverage, please do not hesitate to ask us. We are here to help you.

**I have read and understand the above Financial Policy.**

_____ _____

Signature Date

_____ _____

Witness Date

## LIFETIME AUTHORIZATION INSURANCE ASSIGNMENTS AND AUTHORIZATION TO RELEASE INFORMATION

I. RELEASE OF INFORMATION - I the below named patient, do hereby authorize any physician examining and/or treating me to release to any third payer (such as an insurance company or governmental agency, example: Blue Shield of Florida or Medicare) any medical condition and records concerning diagnosis and treatment when requested by such third party for its use in connection with determining a claim for payment for such treatment and/or diagnosis.

II. PHYSICIAN INSURANCE ASSIGNMENT - I, the below named subscriber, hereby authorize payment directly to any physician examining or treating me of any group and/or individual surgical and/or medical benefits herein specified and otherwise payable to me for their services as described but not to exceed the reasonable and customary charge for these services.

III. MEDICARE/MEDICAID - Patient's certification authorization to release information and payment request, I certify that the information given by me in applying for payment under Title XVIII/XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to Social Security Administration/Division of Family Services or its intermediaries or carries any information needed for this of a related Medicare/Medicaid claim. I hereby certify all insurance pertaining to treatment shall be assigned to the physician treating me.

IV. I PERMIT A COPY OF THESE AUTHORIZATIONS AND ASSIGNMENTS TO BE USED IN PLACE OF THE ORIGINAL WHICH IS ON FILE AT THE PHYSICIAN'S OFFICE. This assignment will remain in effect until revoked by me in writing.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. I understand it's my responsibility to pay any deductible amount, co-insurance, or any other balance not paid for my insurance or third payer within a reasonable period of time not to exceed 60 days.

If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and costs of collection.

Date: _____ Patient: _____
Signature

SUBSCRIBER (if different from patient): _____
Signature

ORIGINAL SIGNATURE ON FILE AT PHYSICIAN'S OFFICE

### MEDIGAP (SECONDARY INSURANCE) SIGNATURE

| NAME OF BENEFICIARY | HEALTH INSURANCE COMPANY | MEDIGAP POLICY NUMBER |
|---|---|---|

I request that payment of authorized MEDIGAP benefits be made on my behalf to *Your Practice Name here* for any services furnished me by (physician/supplier). I authorize any holder of medical information about me to release to *Your Practice name here* any information needed to determine benefits or the benefits payable for related services.

SUBSCRIBER'S SIGNATURE: _____ DATE: _____

Revised: 07/19/95