FAYETTEVILLE UROLOGY ASSOCIATES
Financial Policy and Assignment of Benefits

Thank you for choosing us as your health care provider. We are committed to providing the best possible treatment and service. Your understanding of our financial policies is an essential part of your treatment and our Financial Policy is intended to describe our expectations regarding your financial obligations. Please ask if you have any questions about our fees, our policies, or your responsibilities.

- All deductibles and copayments are due at the time of service as well as any outstanding patient balances. If you have no insurance coverage, payment is due at the time of service unless prior arrangements have been made with our Billing Coordinator. If your copay is a set dollar amount and you do not pay it at the time of service, a $10.00 statement fee will be added to your balance. We accept cash, check, money order, Visa and MasterCard. There is a $25.00 service charge for all returned checks.

- Your insurance policy is a contract between you and your insurance company. As a service to you, we will file your insurance claim if you provide us with the correct information and assign the benefits to the physician. If you have a policy that pays the patient only, you will be responsible for filing the claim and payment in full will be due at the time of service.

- It is your responsibility to inform us in a timely manner of any changes to your billing and insurance information. Failure to provide us with complete and accurate insurance information may result in you being responsible for the entire bill. Please be aware there is a time limit on how long we have to file insurance claims. If we miss the deadline because you did not provide us with the correct information, you will be responsible for payment in full.

- If your insurance company requires a referral form or authorization, it is your responsibility to obtain this from your primary care provider or insurance company prior to your appointment. Failure to obtain the referral and/or authorization may result in a lower or no payment from the insurance company, and the balance will be your responsibility.

- If your insurance company does not pay the practice within a reasonable period, we will transfer the balance to your responsibility. We request your assistance in following up with your insurance company to resolve any non-payment issues. It is your responsibility to pay the bill. We are not providing medical services to your insurance company; we are providing them to you.

- We participate with many, but not all, insurance plans. It is your responsibility to contact your insurance company to verify that we participate with your plan.

- All health plans are not the same and do not cover the same services. You are responsible for any and all portions of the bill denied or "not covered" by your insurance plan. We will attempt to verify benefits and obtain authorization for surgeries and some specialized services; however, you remain responsible for charges for any services rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.

- Patient account balances are due within 30 days of the receipt of the billing statement. If you have an outstanding patient balance over 60 days old and have failed to make appropriate payment arrangements with us or have failed to make agreed upon payments, your account may be subject to collection proceedings. All costs incurred including, but not limited to, collection fees and/or court fees, shall be your responsibility in addition to the balance due to our office.

- We will make every effort to give you a reminder call 2 days before your appointment; however, it is your responsibility to remember your appointment. Unless cancelled at least 24 hours in advance, our policy is to charge for missed appointments at the rate of $50.00 for office visits and $75.00 for office procedures.

Assignment of Benefits

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s) including Medicare, Medicaid, Tricare, private insurance and any other health/medical plan, to issue payment check(s) directly to Fayetteville Urology Associates, P.A. for medical services to myself or my dependents regardless of my insurance benefits, if any.

I have read and understand the practice's financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time.

Print Name of Patient	Patient's Date of Birth
Signature of Patient (or responsible party of minor)	Date