PALETZ AGATSTEIN UROLOGY MEDICAL GROUP, INC

FINANCIAL POLICY OF PRACTICE

Our Practice Financial Policy

We are dedicated to providing you with the best possible care and service and regard your understanding of our financial policies as an element of your care and treatment. To assist you, we have the following financial policy. If you have any questions, please feel free to discuss them with our staff.

Unless other arrangements have been made in advance by either yourself or your health coverage carrier, full payment is due at the time of your service. For your convenience, we accept VISA, MasterCard, American Express and Discover.

Your Insurance

We have made prior arrangements with many insurers and other health plans. We will bill those plans with whom we have an agreement and will collect any required co-payment at the time of service. The co-payment will be collected when you arrive for your appointment. In the event your health plan determines a service to be “not covered,” you will be responsible for the complete charge. In that event, we will bill you and payment is due upon receipt of that statement. A late fee of $25 will be assessed if payment is not received within 10 days of the statement date.

If you have insurance coverage with a plan with which we do NOT have a prior agreement, we will prepare and send the claim for you on an unassigned basis. In this case, your insurer will send the payment directly to you. Therefore, charges for your care and treatment are due at the time of the service.

We will also bill your health plan for all services we provide in the hospital. Any balance due is your responsibility and is due upon receipt of a statement from our office.

Minor Patients

For all services rendered to minor patients, the adult accompanying the patient is responsible for payment. The responsible adult must also show proper photo ID at the time of the appointment.

Missed Appointments

In order to provide the best possible service and availability to all our patients, we ask that you call us as early as possible if you know you will need to reschedule your appointment. Failure to do so may result in a fee for the missed appointment.

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

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY IF MINOR X	TODAY’S DATE
PRINT NAME OF THE PATIENT X	