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FINANCIAL POLICY OF ATLANTIC UROLOGICAL ASSOCIATES

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 IS DUE AT THE TIME SERVICES ARE RENDERED. We accept cash, personal checks, MasterCard, Visa and Discover.

Returned checks are subject to a service charge of $25.00 and you may lose your privilege to write checks in our office.

PRIVATE INSURANCE COMPANIES THAT WE "ARE" A PROVIDER WITH. Co-payment and deductible must be paid at the time of service. If we are unable to verify your insurance coverage, you may be responsible for full payment at the time of the service. Because we are under contract with the insurance company, we will file your insurance claim. If payment is not received from your insurance company within a reasonable time, the full balance will be transferred to the responsibility of the patient (or guardian).

If you provide us with incorrect or invalid insurance information and we need to re-enter and resubmit your corrected insurance information, there may be a $20.00 administrative charge for each claim that has to be refiled.

PRIVATE INSURANCE COMPANIES THAT WE "ARE NOT" A PROVIDER WITH. You will be responsible for payment in full at the time of service and our office will file the claim form as a courtesy with your insurance company.

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 processes the claim. If you have a secondary insurance policy, we will file the claim as a courtesy.

CHILDREN OF DIVORCED PARENTS. Payment will be due from the person who is with the child today no matter who is responsible by divorce decree.

MISSED APPOINTMENTS. We ask for 24 hour's notice to cancel an appointment. Patients who do not call to cancel an appointment may be charged $25. A third no-show may result in the patient being discharged from the practice.

FORMS AND RECORDS. For completion of disability and cancer policy forms, there will be a $10 charge for a one-sided form and a $15 charge for a two-sided form. Medical records requested will have a charge of $1 per page for the first 25 pages, and twenty-five cents for every page thereafter. Forms and records will be released only after the payment has been collected.

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 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 (such as elective sterilization, infertility evaluation, screening lab tests, etc.).

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 90 days, including those that your insurance has not paid, collection action will be taken. We realize that emergencies do arise and may affect timely payment of your account. If such extreme cases do occur, please contact our billing department at (386) 274-1947.

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 Financial Policy.

Signature (Patient, Guardian, or Power of Attorney) _____ Date

Witness _____ Date