UROLOGY CENTER FINANCIAL AGREEMENT (2017)

PLEASE INITIAL BESIDES EACH SECTION TO ACKNOWLEDGE:

_____ Payment is expected at the time of service unless prior arrangements have been made.

_____ "Bounced check" - Checks returned by the bank for insufficient funds fee. $50.00

_____ "No show for appointment" - Failure to keep scheduled appointment fee. $25.00

_____ "No show for procedure" - Failure to keep scheduled procedure appointment fee $50.00

_____ "Cancellation" - Appointment cancellation less than 24 hours fee. $25.00

_____ Charges for completion of work forms (charge per form): $40.00 per form. e.g., disability, FMLA, leave of absence from work. Our simple office form letter / work excuses will be given as a courtesy.

_____ Credit cards accepted: VISA, MasterCard. **Not** accepted: Discover, American Express.

_____ Charges for copy of medical records - sixty cents per page.
Nevada Law has authorized charges up to sixty cents per page. This is to cover manpower & supply costs of copying, disassembling and reassembling your chart, and handling. This service requires payment to an individual &/or company who expects payment for their work. Costs for postage are additional. The fee will be collected before the copy of records is released. A **single courtesy copy** of your records may be FAXED to another physician's office at no charge if you have moved, transferred care, or have been referred to another physician for care.

_____ **Interest Charges for unpaid balances**. Unpaid balances due after **60** (sixty) days will be subject to interest charges. Annual Percentage Rate (APR) of **18 %** will be assessed monthly on past due balances.

_____ Accounts with balances past due for more than 90 days from the date of service will be forwarded to an outside Collection Agency. Payment for Collection and Legal fees (small claims court) are the responsibility of the patient / guarantor.

AGREEMENT TO PROVIDE COMPLETE AND CURRENT INFORMATION:

_____ 1. I agree to notify this office at the time of future service if there has been any change in my address, phone number(s), employer, insurance, or primary care physician.

_____ 2**. I have provided the name of ALL the insurance policies of which I am a member at this time. I will notify this office of any changes at all future office visits. I acknowledge that to withhold this information is INSURANCE FRAUD. I acknowledge that if I give incorrect information, I will be held responsible for all penalties and refunds due, and that I will be responsible for the full cost of my care at my own personal expense.** I agree to notify this office at the time of future service or appointments (or at the time of scheduling the appointment) if there are any changes in my membership status in any of my medical insurance policies**.**

_____ 3. I acknowledge that to provide information from an insurance policy that has been terminated prior to the time of receiving medical care is fraud.

NAME **SIGNATURE** **DATE**