SCOTTSDALE UROLOGIC SURGEONS, LTD. - *OFFICE FINANCIAL POLICY*

Welcome and thank you for choosing our office for your medical care. We hope that by providing you with our policies in advance we can prevent misunderstanding and frustration. Please read this carefully.

Initial _____ SOCIAL SECURITY NUMBERS are a necessary part of your financial information with our office. This information, as with any of your medical record, is protected with strict confidentiality. You are asking us to extend your credit by filing insurance for your charges and not collecting in full at the time of service, therefore we must have this information or all charges must be paid at the time of service. Not providing your social security number at your first appointment will result in you being rescheduled until your social security number is received.

Initial _____ CHECK-IN: Please arrive 10 minutes prior to your appointment time, so that all paperwork may be completed before the time you are scheduled. We also ask that our patients bring their current insurance card to ***each*** appointment. If you do not have your insurance card you will be asked to reschedule or pay for your services. On follow-up visits, you will be asked to verify demographic and insurance information so that our records remain up-to-date. Even if you have not had any changes to your demographic/insurance information, our office does require each patient update on an annual basis.

Initial _____ INSURANCE: Our office will file claims for primary insurance only, unless you have Medicare or AHCCCS. We do not bill secondary insurance plans. When making an appointment with our office it is your responsibility to confirm whether our office is currently under contract with your plan. If payment is not received from your insurance carrier within 60 days of filing the claim, the balance due will become your responsibility. Our office cannot become involved in disputes between you and your insurance company regarding coverage and/or policy benefit criteria, i.e. deductibles, non-covered services, coinsurance, coordination of benefits, pre-existing conditions or "reasonable and customary charges", etc., other than to supply factual information when necessary. Each patient is ultimately responsible for the timely payment of their account.

Initial _____ REFERRALS AND AUTHORIZATIONS: It is your responsibility to understand your benefit plan. It is your responsibility to know if a written referral or authorization is required to see specialists. If you do not have a referral or authorization for your appointment you can reschedule or accept charges in full as your responsibility.

Initial _____ CO-PAYMENTS: Co-payments are due at the time of service. We do not bill for co-payments. We reserve the right to reschedule an appointment if a co-payment is not paid at the time of the appointment. For your convenience we accept cash, check, MasterCard, Visa, Discover and American Express.

Initial _____ PRIVATE PAY: If you have no insurance or an insurance we do not participate with, payment in full is expected prior to your service.

Initial _____ SURGERY/PROCEDURES: Our office reserves the right to collect, prior to surgery/procedure, deductibles and/or co-insurance up to an amount equal to your expected liability. If we do not receive your expected liability prior to the surgery/procedure your appointment/surgery will be cancelled. **Surgeries not cancelled 72 hours in advance are subject to a minimum fee equal to 50% of the surgery fee but may be up to 100% of anticipated surgical charges.**

Initial _____ BALANCES/CO-INSURANCE/DEDUCTIBLES: Please be prepared to pay for the current visit as well as any past due balance on your account. Payment of deductibles and co-insurance will be required at the time of service.

Initial _____ PAST DUE BALANCES/COLLECTIONS: Should there be any balance remaining after insurance has been collected, it will be due 10 days after receipt of statement. If previous arrangements have not been made with our billing department, any account over 60 days will be turned over to a collection agency and 30-40% fee will be assessed to your account to offset the recovery fee.

Initial _____ FEES: There is a minimum $500.00 per hour charge, per doctor, to respond to all claims, disputes, complaints, legal proceedings, hearings and similar, on your behalf or as a result of your care.

Initial _____ NO SHOW/CANCELLATION: A $50.00 fee will be charged to your account should you not cancel your appointment 48 hours prior to your scheduled appointment time. **Surgeries not cancelled 72 hours in advance are subject to a minimum fee equal to 50% of the surgery fee but may be up to 100% of anticipated surgical charges.**

Initial _____ RETURNED CHECKS: A $25.00 fee will be assessed for any returned checks, plus any bank fees.

Initial _____ FORMS: If you have forms for disability, insurance, work forms, etc. to be completed, there is a minimum $25.00 to $50.00 charge per form. Payment is due when the request is submitted to our office. We require a one week turn around (7 business days).

I have read, understand and agree to the above office and financial policies. I have given and agree to provide current demographic and insurance information and authorize release of information necessary for insurance filing, if applicable. By signing this statement, I also authorize my insurance company to reimburse Scottsdale Urologic Surgeons, Ltd. directly for any benefits for which I may be eligible.

Signed: _____Print Name: _____ _____ Date: _____

Some or all of our physicians may have a small financial interest in NVSC, SW Lithotripsy, radiation services & pathology services rev. ***11/30/2010***