PROGRESSIVE UROLOGY, PC

FINANCIAL POLICY

It is our office policy to inform you of our patient payment procedures. Please review our financial policies carefully and let us know if you have any questions or need assistance.

Please initial one:

_____**Patient with insurance:**
You are responsible for deductibles, co-pays, coinsurances and non-covered services. Please pay co-payment amounts as services are rendered. You will be required to pay your unmet deductible prior to any surgical procedures. The remaining balance should be paid in full within 30 days of notice from your insurance company. If you or your insurance carrier makes payment exceeding your balance, reimbursement will be remitted. If payment cannot be made at each visit, notify our billing specialist to make other arrangements.
I understand that in the event that my insurance company does not pay for today's service, if my insurance is not in effect on this date, or if Dr. Carey Ransone is not currently participating in my insurance plan, I agree to, and personally accept full financial responsibility payable to Progressive Urology, PC.

_____**Patient without insurance:**
Please make payment for your care at each visit. If payment cannot be made at each visit, our billing specialist will assist you in completing the Financial Arrangement Statement. We require a $145.00 payment for office visits and 50% down when surgery is scheduled and the other 50% 5 days prior to the surgery date.

- We accept Visa, Master Card, Discover, personal check or cash as payment.
- We require that you notify our office **3 working days** prior to the cancellation of an in-hospital surgery. Otherwise you may be charged a fee of $100.00 for the missed procedure.
- We require that you notify our office at least **24 hours** prior to the cancellation of all appointments. Vasectomy and Urodynamic procedures will be charged $100.00; all other appointments will be charged up to $50.00 for the missed appointment.
- We require a $15.00 fee that will be charged for obtaining medical records. This fee includes the cost and expenses of copying records. It will also include postage if the records are mailed.

RELEASE OF INFORMATION

Please initial:

_____I authorize Progressive Urology, PC to release to my insurance carrier and/or (Medicare) and its agents, any information needed to determine benefits or benefits payable for related services.

_____I authorize Progressive Urology, PC to release pertinent medical information to other physicians involved in my care, (such as PCP) as needed.

I have read and agree to the Financial Policy stated above that apply to me.

_____ _____
Patient or Responsible Party Signature Date

_____ _____
Print Name Relationship to Patient (if not self)