NEW YORK UROLOGICAL ASSOCIATES, P.C.

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Thank you, for choosing us as your Urological health care provider. We are committed to your treatment being successful. The following is a statement of our financial policy that we ask you to read and sign prior to any treatment.

ALL FORMS MUST BE COMPLETED AND SIGNED BEFORE SEEING A DOCTOR

- **MEDICAID:** I understand that the practice is not part of the Medicaid program. As such I agree to pay for all fees incurred in my medical care provided by NEW YORK UROLOGICAL ASSOCIATES, PC or any of their doctors.
- **PRIVATE INSURANCE:** Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Therefore, YOU ARE RESPONSIBLE FOR FULL PAYMENT AT THE TIME OF VISIT
- **PARTICIPATING INSURANCE:** All co-payments and deductibles are payable at the time of visit. Your signature below authorizes payments to us for our services. You are responsible for obtaining a referral number. If you do not, you are required to pay at the time of visit as an "out of network." If your insurance does not cover a special procedure and you would like it performed anyway, you are required to sign an acknowledgement and pay at the time of service. This waives your right to submit it to your carrier for denial.
- **MEDICARE INSURANCE**: We accept assignment. We will electronically submit your claim. Medicare will mail an Explanation of Benefits to you. You can then submit this to your co-insurance. I request that payment of authorized Medicare benefits be made to me or on my behalf to NY UROLOGICAL for services furnished to me. I authorized any holder of medical information about me to be released to the healthcare financing administration agents any benefits for related services.

******MEDICARE BENEFICIARY NOTICE******

Medicare will only pay for services that it determines to be "reasonable and necessary" under 1872(a) (1) of Medicare law. I have been notified on the date indicated that ***Medicare is likely to deny payment for test/treatment if I exceeded the prescribed frequency for either the prescribed test/treatment***. I agree to be personally responsible for payment if Medicare denies payment.

******RELEASE OF INFORMATION******

I hereby authorize NY UROLOGICAL to release to insurance carriers or others who are, or may be financially responsible for my medical care, all information needed to substantiate payment for my medical care. I have read the above and agree to this policy as stated.

******APPOINTMENT CANCELLATION******

Please note: We make every effort to accommodate our patients and arrange for your visit and or procedure requirements in advance. To help us prepare for your appointment and that of other patients more efficiently we request that **All appointment CANCELLATION be done with at least 24 hours** prior notice. **A $50.00 Fee will be invoiced to all late Cancellation, NO SHOWS.**

Print Name_____Date_____

Signature _____