



Thank you for choosing Carson Urologists for your medical care. We are committed to providing care which is efficient, courteous and competent. Due to new **HIPAA** laws regarding your Protected Personal Health Information (PHI) our New Patient packets are lengthy and for this we apologize. The new HIPAA laws are for your protection. We use your PHI only for treatment, payments and healthcare operations. Any other use of your PHI will require additional authorization from you. Please ask for a copy of our Notice of Privacy Policies at the reception desk for all information regarding your Protected Health Information.

OUR FINANCIAL POLICY: (Please take time to read)

Please understand that payment, accurate billing and collection of your bill are considered a part of your treatment. Necessary forms need to be completed to expedite carrier payment. Each time you visit our office you will be required to sign off that we have your most current insurance information or that you do not have insurance. If we bill the incorrect insurance because you did not inform our office of an insurance change, you will receive the bill.

Any charges incurred through the emergency room, consultation in the hospital, and charges incurred in our office are your responsibility. We will be happy to file your insurance for you (workers comp excluded).

Part of our service to you is to complete FMLA/disability paperwork. There is a fee of \$12 per form which is due upon the receipt of the paperwork.

We accept checks, cash, Visa, MasterCard, Discover card or Care Credit. If your check comes back to us for non-sufficient funds, we will charge a \$35 fee to cover the bank charges and we will ask for all subsequent payments to be made by cash or credit card.

You will be required to pay your portion in full at the time of service. If we have filed with your insurance and you have a remaining balance due, you are required to pay the balance in full within 30 days of your statement. If not paid, your account will be referred to our collection agency. **When your account is referred to an outside collection agency your balance will be increased by 50% for collection processing. This can and will impact your financial credibility. This is a substantial amount added to your current balance.**

Disclosure:

I understand that if my insurance carrier denies any charges or I have no insurance to file for services I am responsible for the bill. I have read the financial policy and understand my responsibility.

I am responsible for any deductibles, co-payments or co-insurance at the time of service. Non-payment of my expected co-pay at the time of service will result in an additional \$15.00 fee to my account. This fee covers the administrative cost of a statement the office normally would not have to process.

If you have any questions concerning this notice, please feel free to ask any representative of our office.

Signature: _____ Date: _____

Print name: _____