IRONWOOD UROLOGY OFFICE POLICIES

WE REQUIRE A COPY OF YOUR CURRENT INSURANCE CARD AND PHOTO ID AT EACH VISIT

There are numerous insurance plans with which we have contracted to receive payment direct from the insurance company. With these plans, the patient is generally required to meet a deductible and/or make a copayment. If you are covered by one of these plans, be prepared to make your copayment, or pay for your office visit if your deductible has not been met at the time of service. We accept cash, checks (for amounts under $50.00), VISA, MasterCard and Discover.

It is your responsibility as a consumer to know what benefits are covered by your insurance plan. The most frequent services that are NOT covered in this office (or are covered at a higher copay/deductible) are: infertility, impotence (erectile dysfunction/ED) and vasectomies. In addition, many PPO's charge a co-insurance when procedures of any kind are performed in the office. Vasectomy reversals are never covered by insurance. If you are uncertain if your insurance will pay for a visit/service, please contact member services at your insurance company prior to your visit.

MEDICARE PATIENTS: If you have other insurance in addition to Medicare, It is your responsibility to be clear on which insurance is considered "primary". If your secondary pays you direct (those with whom we are not contracted) or if you have no secondary insurance, we will require the 20% Medicare co-insurance at the conclusion of your visit.
This office cannot accept responsibility for submitting claims to insurance companies who will pay you directly; nor will we negotiate a settlement on a disputed claim.

If your insurance company does not pay our claim within ninety (90) days of filing due to non-response from you (ie, missing info regarding coordination of benefits; pre-existing condition), the balance in full will be immediately due and payable by you upon receipt of our statement.

FINANCE CHARGES
Any balance not paid in full within 30 days of the initial billing is subject to a finance charge of 1.5% on the unpaid balance.

PAYMENT ARRANGEMENTS
Payment is due at the time of service. If you do not have your copay at the time of service, we have the right to reschedule your visit or surcharge your account an additional $10.00 fee for administrative costs. Occasionally there is a need to set up a payment plan. Our business office will be happy to assist you with these arrangements. We are unable to provide payment plans in excess of three (3) months. Payment plans are subject to a 1.5%/month administrative fee on any remaining balance.
Failure to keep a Payment Plan account current will result in our being unable to provide additional medical services. ***In case of default, you will be responsible to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future balance.***

DELINQUENT ACCOUNTS
Accounts that are not paid within sixty (60) days of the first billing (other than those that have made arrangements for a Payment Plan) will be transferred to an outside collection agency. ***You will be responsible to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future balance.***

RETURNED CHECKS
There is a $30.00 service fee for checks returned for insufficient funds/closed accounts/etc. We belong to the Maricopa County Attorney's Office Check Enforcement Bureau.

CANCELLATION OR RESCHEDULING OF APPOINTMENT
If you find it necessary to cancel or reschedule your appointment, we ask that you give us reasonable notice so that we may let another patient have your appointment time. **Cancellations/no shows/reschedules of office procedures (vasectomy, cystoscopy, biopsy, urodynamics, etc.), AND all outpatient and inpatient procedures/ surgeries are charged $150.00 unless you provide us with 48-hour notice. In addition excessive rescheduling of surgeries will also be charged a $150.00 fee. No shows for routine appointments will be charged a $50.00 fee.**

I have read and agree to the above policy of Center for Urological Services, PC. I understand its contents and by signing below, accept the aforementioned financial responsibilities.

_____	_____	_____
Patient Name	Patient Signature	Date

If minor, Parent/Guardian Signature_____