Urology Associates OF DANBURY, P.C.

Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge that I received a copy of the Notice of Privacy Practices. I further acknowledge that a copy of the current notice is posted in the reception area, and that I may request a copy of any amended Notice of Privacy Practices at each appointment.

FINANCIAL POLICY

Insurance:
We have agreements with many insurance plans to accept an assignment of benefits. We will bill those plans with whom we have an agreement and will require you to pay co-payment and unmet deductible/coinsurance at the time of service. Patient will be responsible for any non-covered services.

Due to the prevalence of high deductible insurance policies Urology Associates of Danbury (UAD) will require credit card information to be kept on file with our office. This will be used to cover UNMET deductibles and co-insurances that are not collected at the time of service. Your credit card information will be securely stored by our PCI compliant credit card processor, Global Payment Integrated.

You will receive a statement upon receipt of your explanation of benefits (EOB) from your insurance company. If payment is not made within 30 days of the statement date, UAD will process the balance on the provided credit card.

Letters / Form completion:
At the discretion of the physician, letters and forms requiring medical review and physician signature are subject to a $25.00 fee per form.

Referrals:
If your insurance company requires a referral to see a specialist, you are responsible for obtaining the referral. If the referral is not processed BEFORE your visit you will need to reschedule.

Cancellation/No Show Policy:
Your appointment time is reserved for you with your provider. PLEASE be aware that our policy states that proper notification of 48 hours is expected. A $50.00 fee will be charged per missed office visit. Vasectomy, Botox, Penile Doppler Ultrasounds, and Urodynamic Study appointments require a $100.00 deposit. If you do not cancel the appointment within 48 hours, not including weekends and holidays, the deposit will NOT be refunded.

Minor Patients:
For all services rendered to minor patients, we look to the adult accompanying the patient and the parent or guardian with custody for payment.

Insurance Authorization:
I hereby authorize Urology Associates of Danbury, P.C. to furnish information to insurance carriers concerning my illness and treatment.
I have read and understand the financial policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.

_____ _____
Signature of Patient or Responsible Party if a Minor Date

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Please Print the Name of the Patient Date: 03/22/2022