COVINA VALLEY UROLOGIC MEDICAL GROUP, INC.
ADULT AND PEDIATRIC UROLOGY

PATIENT FINANCIAL RESPONSIBILITY STATEMENT

Covina Valley Urologic Medical Group, Inc. welcomes you to our practice. We work hard to provide the highest quality care to you. Your clear understanding of our financial policy is very important to our professional relationship. Please remember that our contract for services is with you, and it is our policy that you are responsible for our fees regardless of insurance coverage.

Insurance Coverage

- It is **your** responsibility to be aware of your insurance coverage, policy provisions, exclusions and limitations as well as authorization requirements. This information is furnished by the insurance carrier.
- We attempt to verify that your coverage is valid at the time of your visit. However, if your coverage is not in effect at the time of your visit, the financial responsibility is yours.

Insurance Changes

- If **you** have had any changes in your insurance coverage- even if there is only a small change in the co-payment amount or a change in the expiration date of the policy-**you** must notify us. Even a small discrepancy on the claim form can lead to a claim denial.

Co-Payments, Co-Insurance and Deductibles

- Co-Insurance and co-payments are the **patient's responsibility.** Co-Payments are due at the time of visits.
- Deductable are **patient's responsibility**. The deductable is determined by the contract you have with your insurance carrier. We do not know how much each person deductable is and how much has been met at the time of your visit.
- **You** will be responsible for a $25.00 service fee if the bank returns your check for non-payment.

Commercial Insurances

- Although ***Covina Valley Urologic Medical Group, Inc***. may participate with third party payment plans, we perceive your insurance coverage as a contract between the insurance company and you. We will bill your insurance company as a courtesy. However, if collection of payment is denied, the responsibility will be placed immediately on you, the patient.

Medicare

- We participate and accept assignment with **Medicare B**. Any portion of the deductable that has not been met is your responsibility. Patients without a secondary insurance are responsible for the 20%.

HMO Insurance

- We will submit charges for **HMO Insurances**. However, co-pay amounts will be collected prior to your scheduled appointment. In order to be seen by the physician, any referrals required by your

insurance company must be in our office before or at the time of the exam. Otherwise, you will be responsible for the charges from your visit or your appointment can be rescheduled.

Self Pay

- Patients with no insurance coverage are expected to pay in full at the time of service.

Patient Balances

- Payment is due upon receipt of statement. Outstanding balances are due prior to the next appointment. (Unless prior arrangements have been made with our billing department). Balances not paid within the 28 days of the initial billing may be subject to a late fee.

Laboratory Bills

- I understand the outside reference laboratory will bill me directly for all laboratory tests performed by ***Covina Valley Urologic Medical Group, Inc***.

I understand that my Health insurance carrier **may not pay** for certain charges generated for services provided by ***Covina Valley Urologic Medical Group, Inc.*** The denial of payment may occur even if the provider believes certain services are medically necessary based on the prevailing standard of good medical care. These non- covered services may include but are not limited to the evaluation of, diagnostic testing for and the management of: erectile dysfunction, and infertility. I acknowledge that it will be my resposibility to pay for charges and cost incurred in total.

Vasectomy procedures that are not covered by your insurance companies will be charged **$500.00** and paid prior to the procedure. If you insurance carrier pays only a portion you will be responsible for up to the $500.00

Completion Of Forms I understand that there will also be a charge of $20.00 for the filling out of life insurance, disability insurance, and all other forms requiring the staff or physician. I understand that this charge is for each form or letter that ***Covina Valley Urological Medical Group, Inc.*** Is requested to fill out.

_____ _____

Print Patient Name Date

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Signature of Patient (or Responsible Party)

Employee Initital_____

Authorization For Assignment of Benefits and Release Of Information

I hereby authorize and direct payment of my medical benefits to ***Covina Valley Urologic Medical Group, Inc***. for any services furnished to me by the physicians. I authorize the physician to release any information, including diagnosis and the records of any treatment or examination rendered to me or my dependents during the period of such medical services, to third party payers and/or health practioners. In the event that my health plan determines a service to be "not covered", I will be responsible for the complete charges. I agree to be responsible for payment of all unpaid services rendered on my behalf or my dependents, including fees for collection services needed.

_____ _____

Signature of Patient (or Responsible Party) Date

Authorization Of Payments

I understand that ***Covina Valley Urologic Medical Group, Inc.*** will assist me in submitting my claim to my insurance carrier. I hereby authorize payment directly to ***Covina Valley Urologic Medical Group, Inc***. and its physician(s) of medical benefits, otherwise payable to me for services provided. I understand that I am financially responsible for my health insurance deductibles, co-insurance, and non-covered services.

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Signature of Patient (or Responsible Party) Date

Payment Options: Cash, Check, Visa or MasterCard

I have read the above Patient Financial Responsibility statement and as a patient, or legal guardian of a minor or impaired patient, I understand that regardless of any insurance coverage I may have, I am responsible for payment of my account. I have read, understood, and agree to the above Financial Responsibility Statement in accordance with the terms and conditions set forth in the policy of this office. I also hereby attest that I have given accurate insurance information to the best of my knowledge for complete and timely payment.

_____ _____

Signature of Patient (or Responsible Party) Date

_____ _____

Print Name Relation to the Responsible Party