Austin Urological Associates, P.A.

INSURANCE POLICY

It is not possible for the office to keep track of the individual requirements of every insurance plan as they apply to your particular situation. Each plan outlines specific coverage benefits that may stipulate special requirements and/or exclusions, preexisting clauses, or specify contracted facilities/providers for laboratory, x-ray and surgical procedures. Please be aware that some of these stipulations may be in fine print in the insurance brochure and specific benefits may be routinely adjusted. It is also possible for plan benefits to differ within the same employer group depending on the type of contract negotiated. Many HMO policies require referrals for services; if so, *YOU MUST OBTAIN THIS APPROVAL PRIOR TO YOUR APPOINTMENT*. Other plans may limit how often certain services may be rendered.

It is your responsibility to understand your benefits and to contact your carrier for clarification of questions relating to the coverage as it applies to medical issues. If you do not inform us of the *specific provisions* of your contract, you may be responsible for these charges. In addition, if your insurance company does not pay the claim within 45 days, you may receive a statement for that date of service. This is to notify you that your assistance is required in obtaining payment for the claim.

If you do not have your insurance card or information, please be prepared to pay *at the time of service* or to reschedule your appointment. We supply the necessary forms to submit to insurance companies with whom we do not participate so that you may submit the claims yourself. You will personally be responsible for any unpaid balances. *Please pay any copay and/or coinsurance amount at the time of service.*

Providing quality medical care for our patients is our primary concern. If you require any assistance with insurance issues or need to make payment arrangements, please speak with our billing department. Our priority is ensuring that you receive the care that your situation requires.

I HAVE READ AND UNDERSTAND THE OFFICE POLICY STATED ABOVE AND AGREE TO ACCEPT THE RESPONSIBILITIES AS DESCRIBED. I UNDERSTAND THAT I WILL BE RESPONSIBLE FOR PAYMENT OF ANY SERVICES NOT COVERED BY MY INSURANCE COMPANY. I AUTHORIZE THE RELEASE OF ANY MEDICAL OR OTHER INFORMATION NECESSARY TO PROCESS ANY INSURANCE CLAIM TO MY INSURANCE CARRIER, AS NEEDED. I AUTHORIZE ASSIGNMENT OF MEDICAL BENEFITS TO: AUSTIN UROLOGICAL ASSOCIATES, P.A.

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Patient/Guardian Signature

Date: ________________

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Print Name