Arizona Urology Specialists, PLLC

Experienced care one patient at a time

PATIENT FINANCIAL RESPONSIBILITY FORM

Thank you for choosing Scottsdale Center for Urology, PC a division of Arizona Urology Specialists, PLLC ("SCFU"/"AUS") as your healthcare provider. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

Patient Financial Responsibilities

The patient (or patient's guardian, if a minor) is ultimately responsible for full payment for his/her treatment and care. Your insurance policy is a contract between you and your insurance. As a courtesy, we will file your claim. However, the patient is required to provide us with the most correct and updated information about their insurance, and will be responsible for any charges incurred if the information provided is not correct or updated.

Patients are responsible for the payment of copays, coinsurance, deductibles, and all other procedures, treatments or services not covered by their insurance plan. Patients are responsible for contacting their insurance carrier for explanation of any service not covered. **Payment is due at the time of service**, and for your convenience, we accept cash, check, and most major credit cards at our office.

Patients may incur, and are responsible for the payment of additional charges at the discretion of AUS. These charges may include but are not limited to (subject to change at any time):

- Charge for returned checks. $25.00
- Charge for missed appointments without 24 hours advance notice $25.00
- Charge for extensive phone consultations and/or after-hours phone calls requiring diagnosis, treatment, or prescriptions. $80.00
- Charge for copying and distribution of patient medical records. $.20/per copy
- Charge for forms completion, including but not limited to disability and FMLA forms. $25.00
- Charges for providing non-English speaking interpreters. Price varies depending on language
- Any costs associated with collection of patient balances, including 3rd party collection agency fees.

Patient Authorizations

By my signature below, I hereby authorize AUS and the physicians, staff, labs and hospitals associated with AUS to release ALL medical and other information acquired in the course of my examination and/or treatment to the necessary insurance companies, third party payors, and/or other physicians or healthcare entities required to participate in my care.

By my signature below, I hereby authorize assignment of financial benefits directly to AUS and any associated healthcare entities for services rendered as allowable under standard third party contracts. I understand that I am financially responsible for charges not covered by this assignment.

By my signature below, I understand the physicians that treat me may have a financial interest in the facility they refer me to including, but not limited to, surgery centers, lithotripsy centers, labs, oncology treatment centers and medical related entities.

By my signature below, I authorize AUS personnel to communicate by phone, mail, answering machine message, and/ or email according to the information I have provided in my patient registration information.

I have read, understand, and agree to the provisions of this Patient Financial Responsibility Form:

Printed Name of Patient | **Date of Birth** | Printed Name of Guardian (if applicable)

Signature of Patient or Guardian | Date

Waiver of Patient Authorizations

I do not wish to have information released and prefer to pay at the time of service and/or to be fully responsible for payment of charges and to submit claims to insurance at my discretion.

Signature of Patient or Guardian | Date