

Pediatric Urology Associates (PUA) is committed to providing you with the best possible care and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees or your financial responsibility.

**Patients must complete all Information Forms prior to seeing the physician.**  
**A copy of your insurance card(s) will be made for your file**

**Co-Payments** – By law, we must collect your carrier designated copay at the time of service. Please be prepared to pay that copay at each visit

**Non-Copay Plans** – If your plan does not require a copay and we participate, we will accept the designated fee. You are responsible for any deductible and balance your plan indicates on their explanation of benefits, including the full balance charged if insurance carrier deems you responsible due to termination of coverage

**Referrals** – If your plan requires a referral from your primary care physician it is YOUR responsibility to obtain it prior to and have it with you at the time of your visit. If you do not have a valid referral with you or on file, you will be required to RESCHEDULE YOUR APPOINTMENT

**Usual and Customary** – Is a term developed by the insurance carrier industry to reflect “average charges” from specific physicians in designated geographic localities. The usual and customary amount noted on the explanation of benefits (EOB) does not accurately reflect individual charges. Therefore, the usual and customary charges does NOT supercede our fees except as defined for “Out of Network” insurances

**Participating Insurance** – You are responsible for all copays, coinsurance and deductible as required by your participating insurance plans. We will accept the insurance carriers rate as payment in full after your financial responsibilities have been met. Our full fee will be due by the patient if the insurance carrier indicates termination of coverage for a specific date of service

**Out of Network Insurance** – You are responsible for 100% of the charge for any service rendered. If a test/exam is performed during the visit, we will allow 45 days for payment. You will be responsible for payment of 100% of the “allowed amount” as defined on the explanation of benefits from your carrier. PUA will accept a 15% prompt payment discount off the “allowed amount” of any surgical procedure, if payment is received within 45 days of date of service. If payment is not received within 45 days, you will be responsible for 100% of the charges as billed on your PUA statement

**Self Pay Patients** – You are responsible for 100% of the charge for any office services rendered. PUA will accept a 15% prompt payment discount on any surgical procedure if payment is received within 45 days of date of service

**Account Balances** – You are responsible for timely payment of your account. Pediatric Urology Associates reserves the right to reschedule or deny a future appointment on delinquent accounts

I acknowledge that if the provider is not paid in full at the time of service or submits a claim to my insurance company, the provider is extending and otherwise deferring my time to pay the full charge for services rendered until the claim is paid by me or paid or denied by my insurance company. I further acknowledge that in the event my account remains past due and is referred to outside collection, such as a collection agency/law firm, I agree, to authorize said entities to communicate with my insurance company regarding my past due account and further authorize said entities to obtain and/review my credit report

I have read and understand the financial policy as stated above and agree to accept financial responsibility for services provided. I have given all the required information as indicated. I certify that the information given is true and correct to the best of my knowledge. I will notify you of any changes to my current insurance coverage that may occur in the future.

**'PUA' ACCEPTS CASH, CHECKS, MASTERCARD, VISA, DISCOVER AND AMERICAN EXPRESS**

**THANK YOU** for taking the time to review our policies. Please feel free to ask questions or share with us any specific concerns.

\_\_\_\_\_  
(Responsible Party Signature)

\_\_\_\_\_  
(Date)