UROLOGICAL ASSOCIATES OF BRIDGEPORT, P.C.
PATIENT ACKNOWLEGEMENT OF RESPONSIBILITIES

Thank you for choosing Urological Associates as your healthcare provider. We are committed to providing you with the best medical care possible.

Upon registration you will be asked to provide valid identity information. We must obtain a copy of your driver's license or legal form of identification.

This document will outline your responsibilities as a patient of Urological Associates of Bridgeport, P.C. By signing this form you are accepting the below responsibilities.

1. As a courtesy, Urological Associates will bill your insurance carrier, although you will be responsible for whatever balance remains unpaid.

(initial)_____

2. Your insurance policy is a contract between you, the insurance company and/or your employer. It is your responsibility to understand your benefit plan and you are responsible to obtain any referrals from your primary care physician prior to your visit.

(initial)_____

3. If a referral (or authorization) is not present at the time of your visit, you may be asked to reschedule. If you choose not to reschedule, you will be responsible for payment at the time of the visit.

(initial)_____

4. As a courtesy, our office staff may contact your insurance company to determine your responsibility for the services/ care to be rendered. You understand that this information is preliminary and you will be responsible if the insurance company determines your contribution is different from what was initially represented.

(initial)_____

5. Copays are due at the time of service. All balances, including past due balances, deductibles and coinsurances must be paid at the time of service.

(initial)_____

6. For patients without insurance, payment in full is due at the time of your office visit and if you require any hospital surgical procedure, payment in full is required prior to your procedure.

(initial)_____

I HAVE READ AND UNDERSTAND THE ABOVE RESPONSBILITIES. I HEREBY AUTHORIZE UROLOGICAL ASSOCIATES OF BRIDGEPORT, P.C. TO FURNISH INFORMATION TO INSURANCE CARRIERS CONCERNING MY ILLNESS AND TREATMENT. FURTHERMORE, I HAVE READ AND UNDERSTAND THIS POLICY AND I AGREE TO BE BOUND BY ITS TERMS. I ALSO UNDERSTAND THAT SUCH TERMS MAY BE AMENDED FROM TIME-TO TIME BY THE PRACTICE.

Printed name of patient:_____ Patient Signature: _____Date :_____

If patient is a minor:

Responsible Party_____Relationship:_____

Responsible Party Signature_____Date:_____

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UROLOGICAL ASSOCIATES OF BRIDGEPORT, P.C.
PATIENT FINANCIAL POLICY

We are happy to provide you with a bill and/or an explanation of benefits from your insurance company showing your responsibility, if you require a copy. If payment cannot be made, you may be asked to reschedule your appointment.

All patients owing a balance receive reminder calls along with monthly statements.

If you are scheduled for a hospital procedure and have not satisfied your insurance deductible, we will provide you with the estimated payment amount due which we require prior to your procedure.

Balances may be turned over to collections after 60 days if arrangements for payment are not made with our billing office. If arrangements are not made, you will be responsible for all costs associated with collecting monies including court costs, $25.00 collection agency fee and attorney fees.

We require 24 hour notice for canceling any appointments. Any patient who does not arrive for a scheduled appointment is considered a "no show". If you do not notify us within 24 hours you may be subject to a $25 "no show" fee.

A chronic "no show" patient may be dismissed from the Practice.

A $35 fee will be charged for any returned checks and must be paid prior to any future appointments. At that time only a credit card or cash will be accepted. There may be a fee for copies of medical records and certain forms which are completed by the provider.

For all services provided to minor patients, the parent or guardian with custody is responsible for the payment. Minors must be accompanied by a guardian/adult at the time of their visit.

Urological Associates of Bridgeport understands that financial problems may affect timely payment, so we encourage you to communicate any such problems to us so that we may assist you in keeping your account in good standing. If you have any questions, please contact the billing department at 203-381-9388, Monday through Friday 8 am to 5pm.

I UNDERSTAND THE ABOVE INFORMATION AND WILL BE RESPONSIBLE FOR THE PATIENT LISTED BELOW. I HEREBY AUTHORIZE UROLOGICAL ASSOCIATES OF BRIDGEPORT, P.C. TO FURNISH INFORMATION TO INSURANCE CARRIERS CONCERNING MY ILLNESS AND TREATMENT. FURTHERMORE, I HAVE READ AND UNDERSTAND THIS OFFICE FINANCIAL POLICY AND I AGREE TO BE BOUND BY ITS TERMS. I ALSO UNDERSTAND THAT SUCH TERMS MAY BE AMENDED FROM TIME-TO- TIME BY THE PRACTICE.

Printed name of patient:_____ Patient Signature: _____Date :_____

If patient is a minor:

Responsible Party_____Relationship:_____

Responsible Party Signature_____Date:_____

Rev 7/15