ARIZONA INSTITUTE OF UROLOGY, PLLC
CONSENT TO TREAT / FINANCIAL POLICY

Patient Name:_____ Date of Birth: _____

CONSENT TO TREAT: By signing this form I consent to treatment by my primary Arizona Institute of Urology, PLLC (AIU) physician and/or their assistant(s). I am aware that if my primary AIU doctor is unavailable, I will be seen and treated by another AIU physician providing coverage for the Arizona Institute of Urology, PLLC physicians. _____**Initials**

FOR PATIENTS WITH INSURANCE: We bill most insurance carriers for you if proper paperwork is provided to us. We will also bill most secondary insurance companies for you. If your insurance requires a referral or prior authorization it is your responsibility to assure that one is available to our office prior to or at the time of your service. Our office contracts with many insurance carriers, please contact your insurance prior to your appointment to verify you are receiving care from a participating provider. Co-payments, coinsurance and deductibles are due at the time of service. If you are unprepared to pay your co-pay on the day of your visit a $5.00 service fee may be charged to your account. Since your agreement with your insurance carrier is a private contract between you and your carrier, we do not routinely research why an insurance carrier has not paid or why it paid less than anticipated for your care. If you have questions about your benefits or your insurance carriers' decision to pay or deny your claim, please contact your insurance carrier directly. If an insurance carrier has not paid within 60 days of billing, professional fees are due and payable in full from you. _____**Initials**

MEDICARE PATIENTS: We will bill Medicare for you. We will also bill secondary insurance carriers for you. All coinsurance amounts or deductibles not covered by an insurance plan are due and payable at the time service is rendered. _____**Initials**

FOR PATIENTS WITHOUT INSURANCE: Payment in full is due at the time service is provided unless prior arrangements have been made. _____**Initials**

SURGERY FEES: All copays, deductibles, and payments for non-covered surgical procedures are due prior to your surgery. Prior authorization may be required by your carrier. _____**Initials**

NONCOVERED SERVICES: It is your responsibility, as the insured member, to know what your insurance policy covers. Any care not paid for by your existing insurance coverage will require payment in full at the time services are provided or upon notice of insurance claim denial. _____**Initials**

MISSED APPOINTMENTS: In fairness to other patients and to the doctor, we require at least 24 hours notice to cancel appointments. You may be charged a $25.00 fee for missed appointments. _____**Initials**

ASSIGNMENT OF INSURANCE BENEFITS: I hereby assign and authorize payment of my insurance benefits directly to Arizona Institute of Urology, PLLC and/or its providers. I request that payment of any authorized Medicare benefits be made on my behalf. I assign the benefits payable for medical services to Arizona Institute of Urology, PLLC and its providers. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment. _____**Initials**

COLLECTION OF FEES: If I fail to make payment when due and the account become delinquent or is turned over to a collection agency or an attorney of collection I/We agree to pay all collection fees equating up to 50% of the outstanding balance at the time the account is placed for collection services. If legal action is deemed necessary, I/We agree to pay reasonable attorney's fees and court costs in addition to the above costs. _____**Initials**

I have read, understand, and agree to the above financial policy for payment of professional fees.
The patient or parent if patient is a minor is ultimately responsible for payment of all professional fees.

_____ _____

Patient or Parent if Minor Signature Printed Name Date Witness Date