

**PATIENT RESPONSIBILITY FORM**

**Patient Name** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_

**Guarantor Name** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_

This statement sets forth Pediatric Urology of Western New York (PUOWNY) policy as to the handling of patient responsibility balances. Patients are responsible for providing PUOWNY the correct insurance information at the time services are rendered.

Participating Insurance Plans & Assignment: This office will use its best efforts to collect co-payment, coinsurance and deductible amounts at the time of visit where applicable. It is our policy to collect \$80.00 at the time of service from patients holding an insurance policy with an unmet deductible. The Federal Government Agency that administers the Medicare and Medicaid programs, has determined that except for certain circumstances, the discounting or waiving of a patients co-pay or deductible is unlawful. Additionally, under HIPAA regulation, this office is not allowed to discount or waive patient's co-pays or deductibles as outlined by their benefit plan. This office will attempt to obtain payment from primary and secondary insurance carriers. Patients assign PUOWNY the right to receive sufficient monies from said insurance. Any amounts not received by primary or secondary insurance within 45 days of the date of service are the patient's responsibility.

Non-Participating Insurance Plans: If this office does not participate with your insurance plan, payment for services rendered is due at the time of service. Services will be charged at the customary fee schedule (or established self-pay rates).

Non-Covered Services: I understand that my insurance carrier may determine that all or part of the service(s) to be delivered may not be covered. I agree to be held personally liable for any such balances.

No Show/Late Cancellation Policy: It is the policy of this office to collect \$50.00 for any unattended appointments that are not canceled 24 hours in advance.

Returned Checks: Checks that are returned by a bank for insufficient funds or for any reason, are subject to a \$35 service fee.

Financial Policy: Cash, checks and credit/debit cards will be acceptable forms of payment. All patient responsibility balances (after insurance has paid in full) will be billed to the patient every 28 days for three billing cycles with increasingly stronger messages on each statement. Patients that do not pay their balances or contact billing agent to make payment arrangements will be referred to its designated collection agency. Patients are responsible for any attorney fees or collections expenses incurred should their account be delinquent.

Group will refund overpayments to patients or insurance companies within 30 days as notified by billing agent monthly.

**I have read and understood the above and agree to the terms and conditions.**

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**Guarantor Name**

**Date**