UROLOGY ASSOCIATES
OF NORTHEAST FLORIDA

DIPLOMATES, AMERICAN BOARD OF UROLOGY

MARC H. BLASSER, M.D.
CHRIS D. MOORE, M.D.
DAVID S. BARGNESI, M.D.

FINANCIAL POLICY

OUR OFFICE POLICY IS THAT FEES ARE DUE WHEN SERVICES ARE RENDERED.

WE MUST EMPHASIZE THAT AS YOUR HEALTHCARE PROVIDERS, OUR CONCERN IS FOR YOUR HEALTH AND OUR RELATIONSHIP IS WITH YOU - NOT YOUR INSURANCE COMPANY.

WE WILL GLADLY DISCUSS THE COST OF YOUR VISIT AND DO OUR BEST TO ANSWER ANY QUESTIONS RELATING TO YOUR INSURANCE COVERAGE. HOWEVER, **YOU MUST REALIZE THE FOLLOWING**:

- YOUR INSURANCE IS A CONTRACT BETWEEN YOU, YOUR EMPLOYER, AND THE INSURANCE COMPANY. WE ARE NOT PARTY TO THAT CONTRACT. YOU ARE ULTIMATELY RESPONSIBLE TO KNOW WHAT YOUR POLICY PROVISIONS ARE AT THE TIME OF SERVICE.
- IF YOU HAVE INSURANCE AND WOULD LIKE US TO FILE CLAIMS ON YOUR BEHALF, YOU MUST PROVIDE ACCURATE INFORMATION *(INCLUDING YOUR SOCIAL SECURITY NUMBER)* AND PRESENT ID CARDS PRIOR TO BEING SEEN.
- IT IS ALSO YOUR RESPONSIBILITY TO OBTAIN A CURRENT REFERRAL FOR YOUR OFFICE VISIT. IF YOU FAIL TO DO SO, YOU WILL BE RESPONSIBLE FOR ALL CHARGES INCURRED
- <u>YOU ARE RESPONSIBLE FOR THE BALANCE OF CLAIMS THAT ARE NOT PAID WITHIN 90 DAYS. AFTER THAT POINT, IT WILL BE UP TO YOU TO CONTACT YOUR INSURANCE COMPANY FOR PAYMENT / REIMBURSEMENT.</u>

I DO HEREBY AGREE TO PAY ANY AMOUNT THAT MY INSURANCE REFUSES AND THAT I WILL BE HELD RESPONSIBLE FOR THE BALANCE OF MY ACCOUNT. I AUTHORIZE PAYMENT OF INSURANCE BENEFITS RESULTING FROM MY CARE IN THIS OFFICE TO UROLOGY ASSOCIATES OF NORTHEAST FLORIDA.

SIGNATURE: _____ DATE: _____