Gillespie County
UROLOGY

Acknowledgement of Financial Policy

Please read the following and initial in the space provided to acknowledge your understanding of Michael C. Speck, M.D., P.A. financial policy.

_____ I understand that the office will copy my insurance and driver's license. It is my responsibility to notify the office of an insurance coverage change.

_____I understand that payment of copayments, deductible, and percentages not covered by my insurance carrier are due at the time services are rendered.

_____I understand that a $30 service fee will be applied to all returned checks.

_____I understand that I am responsible to know my insurance benefits and that I am responsible for any balance not covered in my explanation of benefits.

_____I understand that Michael C. Speck, M.D., P.A. is a Medicare provider and will submit all claims to them. If I am a Medicare recipient, I know I will be responsible for annual deductibles, 20% coinsurance, and any charges the Medicare states that I am responsible for.

_____I understand it is my responsibility to know the details of what my insurance plans covers and am responsible for charges that my insurance does not cover.

_____I understand that Michael C. Speck, M.D., P.A. requires 24-hour cancellation/rescheduling appointment notice and a charge of $25.00 and $50.00 will apply for office visits and procedures without proper notice.

_____I understand that ultimately it is my responsibility to obtain any necessary referrals if my insurance carrier requires one to see a specialist. Also, that if a proper referral is not obtained by the time services are rendered, I will be financially responsible for those services.

INSURANCE BILLING:

I hereby authorize Michael C. Speck, M.D., P.A. to furnish my insurance company with all the information that they may request concerning my present illness or injury. I assign Michael C. Speck, M.D., P.A. all money to which I am entitled for medical expenses related to the service reported. I understand that I am financially responsible to Michael C. Speck, M.D., P.A. for charges not covered by this assignment.

All Information that I have provided pertaining to my account is accurate and true to the best of my knowledge.

SIGNATURE:_____DATE:_____

If you have questions about your insurance coverage, please call us at 830-304-1666 during regular office hours.