Acknowledgement of Financial Policy

***You must put your initials in the blank to be a patient at Gillespie County Urology.**

PAYEMENT OF BALANCES IS DUE IN FULL AT TIME OF SERVICE unless other arrangements have been made in advance by either you or your health insurance carrier. We accept Visa, MasterCard, Discover, American Express, Checks and Cash.

_____ I understand that payment of copayments, deductible, and percentages not covered by my insurance carrier are **due upon the receipt of a statement from our office or at time of service,** whichever comes first.

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

_____ 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 the responsibility of the guarantor to know the details and benefits associated with their insurance plan or coverage and to obtain all referrals and authorizations from the primary care physician, when applicable. **If you do not have a current referral or authorization on file, you may be asked to reschedule your appointment.** Also, if a proper referral is not obtained by the time services are rendered, **I will be financially responsible for those services.**

_____ Surgery deposits are due **5 business days** prior to surgery. If for any reason surgery needs to be cancelled it must be done **10 business days** in advance or a **$150** cancellation fee may be charged to the patient.

_____ Vasectomies will be paid in full before the procedure and will be reimbursed based off of insurance payment. Vasectomy payment does not cover lab fees. We will submit your insurance information to the lab but you are ultimately responsible for lab fees.

_____ I understand that Michael C. Speck, M.D., P.A. requires 24-hour cancellation/rescheduling appointment notice. A charge of **$50.00** for office visits and **$100.00** for procedures will apply without proper notice.

_____ Upon request, our staff provides an **estimate** of costs for services. However, the actual cost of services is established according to the level of care needed as determined by your provider at time of service.

_____ A **$25** fee is required for forms completed by physicians. (ex. Disability, FMLA, etc.)

_____ I understand that a **$30** service fee will be applied to all returned checks.

_____ **$25** Fee for Medical Records.

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. If I do not pay my balance, I will be sent to collections in 90 days. I understand that I may be eligible to set up a payment plan. I understand that I can be fired from Michael C. Speck, M.D., P.A. for not paying my balance.

I have read and understand the financial policy of the practice, and I agree to be bound by its terms. I also understand and agree that the practice may amend such terms from time to time.

SIGNATURE of Responsible Party_____DATE:_____

If you have questions about your insurance coverage, please call the phone number on the back of your insurance card.