Label

REQUIRED SIGNATURE FORM

All agreements are in effect until I choose to cancel them.

__________ Initials: RECORD RELEASE: I agree that my medical and/or billing information may be given to/ or sent to Metro Urology, my referring doctor, insurance company and/or treating facility.

__________ Initials: ASSIGNMENT OF BENEFITS: I agree that my insurance company should send payments of medical benefits for myself and/or my dependants directly to Metro Urology for services rendered.

__________ Initials: CONSENT FOR USE OF MEDICAL RECORDS IN RESEARCH: *Unless I place an "X" through this paragraph,* I agree that Metro Urology can use/release my medical record, which includes all visits to this facility, for research purposes.

__________ Initials: HIPAA – NOTICE OF PRIVACY PRACTICES: I acknowledge that I have reviewed Metro Urology's HIPAA policy and I understand the full HIPAA policy is available for review at the front desk and on Metro Urology's website. I have read and understand that my protected health information may be used for normal healthcare business for scheduling appointments, planning my treatment and obtaining payment from insurance companies.

__________Initials: CONSENT TO LEAVE MESSAGES: I agree that Metro Urology may communicate with me concerning myself and/or my dependants' treatment (lab results, appointment reminders) fax/ voice messaging, email and/or pager.

__________Initials: LAB BILLING/OUTSIDE LAB BILLING: When having lab work performed at Metro Urology, some testing may be sent out to an outside laboratory for further analysis and you may receive a second statement from the outside laboratory as well. By signing below you are agreeing to pay for these procedures if your insurance does not provide coverage or applies these charges to your deductible, co-pay or co-insurance. Applicable insurance adjustments will be applied, per your individual policy.

------------- Initials: NO SHOW POLICY: After the 2nd and subsequent "No-show" clinic visit within 12 months you will be assessed a $25.00 no show fee. If you "No-Show" after the 2nd and subsequent procedure you will be assessed $50.00. See complete policy on the internet or at our receptionist desk.

__________Initials: CONSENT TO DISCUSS MEDICAL/FINANCIAL INFORMATION: If I have agreed, to the paragraph directly above, to have Metro Urology leave messages, then I agree that the following person can discuss my medical/financial information on my behalf.

____ ____

Authorized contact person Relationship to myself

____ ____

Signature **Date**

MEDICARE SIGNATURE FORM

I request that payments for my Medicare benefits be paid directly to Metro Urology for services rendered. I agree that my medical information may be released to the CMS (Centers for Medicare & Medicaid) and its agents in order for my medical claim to be processed and/or reviewed. I agree that a copy of my authorization may be used in place of the original.

Signature: ____ **Date:** _________________________

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FINANCIAL POLICY

Metro Urology is pleased that you have selected our practice to provide Urologic care for you or your family. In order to better serve your needs and avoid confusion, it is important for you to understand our financial policy.

Metro Urology will process any and all U.S. based insurance claims on behalf of our patients. Since it is impossible for us to keep track of every insurance plan and how it works, we expect you to know your coverage, (especially for supplies), copay and /or deductible levels. Metro Urology will assist you with your insurance coverage and paperwork to the best of our ability if you present your current insurance card or information at the time of service. Without current insurance information, you will be entered into our system as a self-pay patient. You are required to make a 100 dollar down payment (before treatment) and you will be billed for the remainder amount of the visit.

Forms of Acceptable Payment: Metro Urology accepts cash, checks or major credit cards. In the event that a check is returned as non-payable, Metro Urology may charge a service fee. In cases of dual custody, payment is required at the time of service regardless of who brings the child in for the appointment. If you do not have insurance, we will require payment at the time of service. You should contact our Business Office at 651-999-7020 to discuss payment arrangements if necessary.

Copay/coinsurance/deductibles: All copays/coinsurance/deductibles required by your insurance plan are collected at the time of service. Patients receiving urodynamic services should be aware that although these services are diagnostic in nature, they may be considered surgical by your insurance company and therefore may require a separate copay or coinsurance.

Referrals/pre-cert/prior auth: If an insurance referral from your primary care physician is required, you must present it at the time of service. If you choose to be seen without the appropriate referral in hand, you agree to be responsible for the charges should they not be covered by your insurance. Patients are also responsible to do prior authorizations, pre-certifications, or to complete any other insurance requirements as necessary.

Supplies: In most cases we require payment for supplies when they are issued. We will submit all supply charges to your insurance company and will reimburse you should they pay. (e.g. Erec-aid devices, EMG sensors, vasectomy clips). Supplies purchased will be accepted for return only according to the manufacturer's warranty. Metro Urology is NOT liable for any defects arising from the use or misuse of any manufactured products that it distributes and provides no warranty as to their performance or result.

Disputes: If for any reason you dispute coverage or payments made by your insurance company, it is your responsibility to contact your insurance company and to resolve the matter based on your insurance company's arbitration or resolution process. We will provide documentation (providing your signature of authorization is on file) to assist in the dispute resolution process. During this time, you will be asked to pay in full the balance or schedule payment arrangements by contacting the Business Office at 651-999-7020.

I understand and agree that regardless of my insurance, I am ultimately responsible for the balance of my account for any services rendered. I acknowledge that I have read and understand all of the foregoing and authorize Metro Urology to treat me and/or my dependants.

Patient Signature ____ **Date** __________________________

Guardian or Family Member if patient is unable to sign ____

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