Care Center
5560 Kletzke Ln.
Reno NV 89511
(775) 322-7811

Advanced Prostate Cancer Clinic
10745 Double R Blvd.
Reno NV 89521
(775) 322-7811

FINANCIAL INFORMATION

I understand that I, as the patient, parent and/or legal guardian, am fully responsible for payment of my/our account with Urology Nevada. All professional services rendered are charged to the patient, parent and/ or legal guardian. It is my responsibility to pay any deductible amounts, co-insurance and/or balance not paid by my insurance company. All deductibles, co-insurance and co-payments are due at the time of service unless prior arrangements are made. A $25.00 administration fee will be assessed for failure to make these payments at the time of service. Necessary forms will be completed to expedite insurance carrier payments. It is also my responsibility to notify Urology Nevada of any changes affecting my/our billing status, such as: Address, telephone number and insurance coverage changes. I agree to pay all attorney fees and/or collection fees should collection proceedings become necessary. I also understand that a charge of $25.00 will be assessed for any unpaid or otherwise dishonored check returned by my bank or financial institution. In that event that I do not show up for my scheduled appointment or cancel it within 24 hours, I may be charged a $50.00 FEE which is not billed to the insurance company and is due before another appointment will be made. I authorize and assign any payment directly to Urology Nevada. I also assign any surgical and/or medical benefits otherwise payable. My consent is granted to use this original or a copy as effective and valid as the original.

I agree that it is my responsibility to verify that Urology Nevada is a participating provider with my insurance plan. Should Urology Nevada not be a preferred provider on my plan, I agree to pay for services rendered based on my out of network insurance benefits. Further, any diagnostics/ screening tests ordered by Urology Nevada physicians that are deemed a non-covered benefit of my insurance become my financial responsibility. Diagnostic and screening tests are ordered to provide quality medical care; they are not based on insurance coverage. Every effort will be taken to assure coverage and I agree that Urology Nevada will not be responsible for my insurance coverage and the financial burden and knowledge of my benefits are my responsibility. Should I have any questions regarding my insurance benefits and coverage, I will contact my insurance company prior to the completion of any testing. If I provide incorrect information that requires a refund to the insurance company, I will be charged a fee and may be responsible for the entire bill. If I have signed with an HMO and did not get a referral to this office, I will be responsible for all charges for the services rendered. If I have indicated the incorrect laboratory or radiology group on my demographic page, I will be responsible for those payments.

IF YOU ARE NOT AN ACTIVE PARTICIPANT IN YOUR HEALTH CARE OR ARE DELINQUENT IN YOUR PAYMENT, YOU WILL BE REMOVED FROM OUR PRACTICE. IN THE EVENT THAT YOU ARE TERMINATED FROM OUR PRACTICE DUE TO NON-COMPLIANCE IN YOUR MEDICAL CARE, NON-PAYMENT, OR INAPPROPRIATE BEHAVIOR TO OUR STAFF, WE WILL CONTINUE TO SEE YOU ON AN EMERGENT BASIS FOR 30 DAYS. AFTER THAT TIME, YOU WILL BE REQUIRED TO SEEK MEDICAL ATTENTION ELSEWHERE IN THE COMMUNITY.

RELEASE OF INFORMATION

I authorize the release of any information regarding the course of the examination and treatment to the applicable insurance company and/or physicians who provide services to me or the person under my care. I further authorize Urology Nevada to obtain medical information from any source necessary for my treatment. A copy of this authorization shall be considered as effective and valid as the original. In the case of legal "Guardianship", I am authorized to sign the release of information outlined above. (You must provide a copy of the legal guardianship documents).

I HAVE READ AND UNDERSTAND THE ABOVE FINANCIAL INFORMATION AND RELEASE OF INFORMATION AND AGREE TO THE TERMS MENTIONED.

_____ _____

Patient Name (please print) Guardian Name (please print)

x_____ _____ x_____ _____

Patient Signature Date Guardian Signature Date