Reno: 5560 Kietzke Ln, Reno, NV 89511
Sparks: 5070 Ion Dr, Ste 201, Sparks, NV 89436
Carson City: 1946 Old Hot Springs, Rd, Carson City, NV 89706
Phone: (775) 322-7811
Oncology Nevada: 10745 Double R Blvd, Reno, NV 89521
Phone (775) 850-6505

PATIENT FINANCIAL AGREEMENT

The mission of Urology Nevada is to provide the highest quality urologic care, tailored to the needs of each patient and to achieve our mission in providing care, all patients, parents, and /or legal guardians are required to adhere to the financial principles outlined below.

PAYMENT FOR OFFICE VISITS

For patients covered by health insurance: Payment of co-payments, co-insurance, and estimated deductible amounts is required at the time of service. If payment is not made, then your appointment will be rescheduled.

For cash pay patients: Payment of your estimated responsibility is required at the time of service. If payment is not made, then your appointment will be rescheduled. Additionally, an estimate is just that, an estimate and depending upon the services you receive, you may owe more than the estimated amount quoted to you.

PAYMENT FOR PROCEDURES OR SURGERIES

For patients covered by health insurance: Payment of co-payments, co-insurance, and estimated deductible amounts related to the professional fees of a procedure or surgery must be paid 7 to 10 days prior to your appointment *unless prior payment arrangements have been made with our billing department.* If payment is not received 7 to 10 days prior to your appointment, then it may be rescheduled.

For cash pay patients: Payment of the estimated responsibility related to the professional fees of your procedure or surgery must be paid 7 to 10 days prior to your *unless prior payment arrangements have been made with our billing department.* If payment is not received 7 to 10 days prior to your appointment, then it may be rescheduled. Additionally, an estimate is just that, an estimate and depending upon the services you receive, you may owe more than the estimated amount quoted to you.

MEDICAL INSURANCE

Our office requires a copy of your current insurance card to be on file. Additionally, you must provide changes in insurance coverage to our office prior to your appointment. *Failure to provide correct insurance information to our office prior to your appointment or within your insurance plan's claim submission period will result in the patient being held financially responsible for the full billed amount for services provided.*

You are responsible for verifying if our office is an in-network provider with your insurance. If our office is out-of-network with your insurance, you agree to pay for services based upon your out-of-network benefits, if applicable, or if you do not have out-of-network benefits, you agree to be a cash pay patient.

Additionally, you are responsible for knowing the coverage and benefits of your insurance plan, specifically co-payment, co-insurance, deductible, and maximum out of pocket amounts.

We encourage all patients to call their insurance carrier with any questions related to their insurance plan coverage.

REFERRALS

If your insurance requires a Primary Care Provider (PCP) referral for you to see a specialist, it is your responsibility to obtain the referral to our office prior to your scheduled appointment. If a required referral is NOT ON FILE at the time of your visit, you will be given the choice to reschedule your appointment for a future date or you may be seen as a cash pay patient.

RETURNED CHECKS

A $60 service charge will be assessed on all returned checks due to insufficient funds. Furthermore, once a check has been returned by a financial institution our office will no longer accept check payments from you and all future payments must be paid by cash or card only.

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Credit Card on File, Deposit, and Prepayment Policy

To streamline the billing process and to ensure timely payment, our practice requires a valid credit or debit card to be placed on file at the time of scheduling an appointment. *Appointments will not be scheduled without a card on file.* By scheduling an appointment and placing a card on file, the patient or guarantor acknowledges and agrees that the card may be charged up to 24 hours prior to the scheduled service for the estimated amount due. Patients will be provided with the estimated amount in advance, allowing them time to review the charge and, if needed, request a different card be used for payment.

The card on file will be charged for late cancellation and no-show fees. Please refer to the late cancellation and no show policy listed below for more information.

COLLECTION AGENCY

Patient balances over 90 days past due will be transferred to our outside collection agency and once the balance is transferred to the outside collection agency, our office will not accept payment on the balance as payment can only be made to the outside collection agency, and the balanced must be paid in full to the outside collection agency before the patient may return to our office.

LATE CANCELLATION AND NO SHOW POLICY

Office appointments cancelled with less than 24 hours' notice or a no showed appointment are subject to a $100 charge for each occurrence.

Procedure appointments cancelled with less than 48 hours' notice or a no showed appointment are subject to a $150 charge for each occurrence.

Surgery Appointments cancelled with less than 48 hours' notice or a no showed appointment are subject to a $300 charge for each occurrence.

No show and cancellation fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment. *Fees may be waived by management approval only.*

In the event of 3 documented no show or late cancellation within a 12 month period, the patient may be subject to dismissal from the practice.

RELEASE OF INFORMATION

This form must be signed for us to bill your insurance; failure to do so will mean you are responsible for all insurance billing.

Assignment of insurance benefits: I hereby authorize my insurance to pay directly to Urology Nevada the amount due on my claims for services rendered to myself or my dependent. Furthermore, 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", you must provide a copy of the legal guardianship documents.

_____	_____
Patient Name, printed	Guardian Name, printed
_____	_____
Patient Signature Date	Guardian Signature Date