UROLOGY LTD.

EXCELLENCE IN UROLOGIC CARE FOR OVER 60 YEARS

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FINANCIAL POLICY

To assist us in providing the most efficient and reasonable health care services, it is necessary for us to have a financial policy which states our requirements for payment of services we provide to our patients.

Urology, Ltd. is committed to providing you with the best possible care. Charges for services rendered are determined based on usual and customary fees for this area. Should you have any questions regarding your bill, please contact our billing department at 847-214-5110.

Patients are responsible for payment of all services provided by Urology, Ltd. All co-pays shall be paid at the time of the office visit. It is our policy to file your insurance claim *as a courtesy*, if we have accurate and complete insurance information. Because our relationship with your insurance is important, we cannot legally write-off your co-pay, coinsurance or deductible. Patients without insurance are responsible for 100% of the fee at the time of service. If you need to make special payment arrangements, contact our billing office.

Your health insurance is a contract between you and your insurance company. It is your responsibility to obtain a referral from your primary care physician, if necessary. **You are responsible for any balance not paid by the insurance company within 60 days.** Please be aware that some services may not be covered by your insurance company. We expect payment within 28 days after we mail a bill to you.

Assignment of Insurance Benefits: I hereby authorize direct payment of benefits to Urology, Ltd. for services rendered.

Authorization for Release of Information: I hereby authorize Urology, Ltd. to release any medical information necessary for the processing of my insurance claim if requested by my insurance company.

I hereby understand the financial policy of this office. I guarantee payment of all charges incurred for the account of the patient listed below. I further agree to pay any attorney's fees, court costs, and related collection fees incurred should it become necessary to refer my bill to a collection agency.

_____ _____

Signature of Patient or Responsible Party Date

PATIENT NAME: _____