FINANCIAL RESPONSIBILITY AGREEMENT

I hereby authorize payment of my medical benefits billed to my insurance to Coastal Urology. I accept responsibility for payment for any service(s) provided to me that is not covered by my insurance.

I agree to provide all current insurance information at the time of service including presenting my insurance card.

I agree to pay my co-payment at the time of service.

I agree to pay my account balance, which may include any deductibles, co-insurances or non-covered charges in accordance with my healthcare coverage. All patients are responsible for their in-network deductible and co-insurance. No verbal agreements or waivers will be honored.

I agree to pay for services, which my insurance company defines as non-covered or not medically necessary. If your claim is denied, you are responsible for the payment of the service.

I agree to have a current and active referral at the time of service (if applicable). If at the time of my appointment I do not have my referral, my appointment will be canceled and rescheduled or I will pay cash for my service. Coastal Urology is not responsible for obtaining referrals and will not call your primary care physician at the time of service.

I agree that I am responsible for knowing the details of my insurance policy and benefit plan. Coastal Urology is not responsible for obtaining your benefit information.

I agree to have Coastal Urology appeal my claims to my insurance company on my behalf if a service is denied or if a payment is deemed unreasonable.

We wish to stress that financial responsibility for services rendered is ultimately the responsibility of the patient or his or her family regardless of the nature or extent of insurance coverage. If your insurance provider does not pay your bill in a timely manner, you will be responsible for payment of the bill.

We are required to ask our patients to prove their identity by showing a photo ID and by answering certain questions that only you or your family members would know when you contact us by phone. We appreciate your cooperation with our efforts to protect your identity and comply with federal regulations.

I HAVE READ THE ABOVE STATEMENTS AND AGREE TO THESE TERMS FULLY

X_____ _____

Print Patient Name **Date**

X _____

Patient Signature