

**Care
Provisions
Policies 2022**

Five Valleys Urology, PLLC

We appreciate the opportunity to serve you and pledge to provide you our best medical care, with compassion, in a safe environment. In order to make our relationship with you the best it can possibly be, please be familiar with and agree to the following policies:

Administrative Policies

- We promise to value your time, and we will inform you as soon as possible if your provider is running late or has been called to surgery. In return, we expect you to arrive on time for your appointments, with all necessary information needed to complete your encounter.
- Many appointments require collection of a urine sample, so please check with the front desk upon arrival before going to the bathroom.
- To respect other patients, we ask that cell phones be turned on vibrate mode while in our office. Please refrain from using verbally abusive language, threatening any employee, provider, patient, or otherwise hostile behavior. Using such is cause for immediate termination from this practice.
- In-office procedures require extra supplies and time. No-showing or canceling a vasectomy, MonaLisa, Urolift, SpaceOAR, or Urodynamics test within 24 hours will result in a \$100.00 cancellation fee.
- Missing or no-showing your appointment creates an undue burden and increases the cost of care to other patients. Missing three appointments without notice will result in dismissal from this practice.

Insurance & Billing Policies

- If you want us to bill insurance, please bring your card to every appointment; without it we cannot bill your carrier. We are required to collect co-payments and co-insurance and reserve the right to re-schedule or cancel appointments to comply with insurance company agreements.
- Health insurance is an agreement between you and your insurance carrier. You are responsible for understanding your own coverage. Your insurance company makes the determination of your eligibility. You authorize your insurance benefits to be transferred directly to the rendering provider and acknowledge you are financially responsible for paying any co-insurance amounts. You agree to pay for services rendered within the limits of this care provisions policy.
- If you do not have insurance, wish not to provide your social security number, or choose not to file a visit with your insurance, a minimum payment of \$100 at time of service is required. The remaining balance for services received will be addressed in our billing statement.
- Many insurance companies have lists of approved drugs they cover. Your provider will prescribe the medication they feel will best address your needs. We will do our best to respond to prior-authorization requests from your insurance company, but this process may delay your prescription. You are responsible for contacting your insurance provider with any questions or requests concerning approved medications.
- Disability, FMLA, and other form completion requests will be processed after a form fee of \$25.00 is received.
- We accept cash, check, credit card, and CareCredit. Payment in full is due within 30 days of your first statement unless other arrangements have been made. We send two statements at 30-day intervals. You understand and agree that if we send your account to collections for non-payment, a fee of 35% of the unpaid balance will be added. This amount shall be in addition to any other cost incurred directly or indirectly to collect amounts owed under this agreement. We offer a financial aid program to patients who meet the criteria.
- If you need a surgical procedure, our surgery coordinator will assist you in scheduling. Although we seek prior authorizations, insurance carriers state they are not a guarantee of payment. You must call your insurance carrier to verify they will cover your procedure.
- If you get lab or imaging tests as part of your appointment, remember some tests/labs are performed by outside parties; in such cases they bill separately. If you know your insurance carrier only covers certain labs or facilities, please notify our office in advance.

By signing below you agree to the terms of service provided herein.

Signature (patient or guardian)

Date

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