Care Provisions
Policies **Five Valleys Urology**

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 the following policies:

Administrative Policies

- We promise to inform you at check-in if your doctor is running late or has been called to surgery.
- 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.
- In-office procedures such as vasectomy require extra supplies. Canceling a vasectomy within 24 hours of appt. will result in a $75.00 sterile tray fee. Canceling Urodynamics within 72 hours will result in a $100.00 fee. By scheduling an in-office procedure you agree to these terms.
- Missing or no-showing your appointment creates an undue burden and increases the cost of care to other patients. Should you miss three appointments without notice, you will be dismissed from this practice.
- We promise to treat you with respect & dignity in a professional and caring manner. In return we expect you to refrain from using verbally abusive language, threatening any employee or provider, or otherwise hostile behavior. Using such is cause for immediate termination from this practice.
- When you are placed in an exam room, we will partially shut the door to protect everyone's privacy.

Insurance & Billing Policies

- If you have 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.
- Your health insurance policy 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 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 or credit card. We send two statements at 30-day intervals; afterwards delinquent accounts are turned to collections. You understand and agree that if we are forced to send your account to collections, 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

Over

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Privacy
& Confidentiality Notice **FIVE VALLEYS UROLOGY**

(Reference Federal Register 45 C.F.R. § Part 164.506)

I understand that protected health information (PHI) may be used and disclosed to perform treatment, payment and/or healthcare operations. I acknowledge I've been given the opportunity to read and review a complete copy of the Five Valleys Urology Privacy Notice with a complete description of such uses and understand I had a right to review the privacy notice before signing below. I understand I have a right to request this office restrict how my information is used, but this office may not agree with the requested restrictions. I have a right to revoke this authorization and consent, in writing, at any time. This office reserves the right to amend the privacy policy, whether required by law or otherwise, and a revised notice may be obtained by calling our office or physically coming to our office.

________________________ ________________________ __________
Printed Name Signature Date

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Additional Privacy & Communication Considerations

Some patients want other individuals, such as family members, to have access to their PHI. In order to comply with strict legal standards, a written release is required to allow another person access to your medical record, even if that other person is your spouse or partner. This release grants permission to the individual(s) listed below to: Make or confirm appointments, have access to x-ray and laboratory findings, pick up sample medications, be made aware of your diagnosis, prognosis, and treatment plans, and serve as your emergency contact. This permission applies to telephone and answering machine messages as well as other means of communication and will be in effect unless I notify this office of any changes or revocations.

1. Designated Party: ____________________ Tel:____________Relation:_________

Is this person also authorized to discuss financial matters? □ Yes □ No

2. Designated Party: ____________________ Tel:____________Relation:_________

Is this person also authorized to discuss financial matters? □ Yes □ No

3. Designated Party: ____________________ Tel:____________Relation:_________

Is this person also authorized to discuss financial matters? □ Yes □ No

May we leave messages or voice mails that might contain PHI? □ Yes □ No

May we send email that might contain PHI? □ Yes □ No email:________________________

May we send text messages that might contain PHI? □ Yes □ No cell:____________________

________________________ ________________________ __________
Printed Name Signature Date
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