Silverwood Urology

TERMS AND CONDITIONS

Patient's Name ____ Today's Date _______________

Last *First* *MI*

Person to contact in an **emergency** ___________________________ Relationship _______________

Phone Number: (_____) ________________ Alternative Phone Number: (_____) _______________

AUTHORIZATION & ASSIGNMENT

[_______] I authorize ***Silverwood Urology*** to perform necessary and advisable procedures for the purpose of diagnosing or treating my medical condition(s). I understand that I will be informed of any and all proposed medical procedures or treatment recommendations prior to commencement, except in the case of an emergency. I also understand that I have the right to refuse any proposed medical procedure or treatment.

[_______] I authorize ***Silverwood Urology*** to disclose the contents of my medical record to my insurance company, if requested.

[_______] I authorize and request ***Silverwood Urology*** to provide pertinent contents of my medical records to the following health care providers: ____________________________________

Providers must be identified individually by name.

[_______] I hereby assign and approve the direct payment to ***Silverwood Urology*** of any insurance benefits otherwise payable for the diagnosis and treatment of my medical condition(s). In addition, I fully understand that I am financially responsible to ***Silverwood Urology*** for all charges not covered by this assignment of benefits.

Signature: ____ Date: _______________

Patient, Parent, or Legal Guardian

PAYMENT & CREDIT POLICIES

Silverwood Urology operates on a fee-for-service basis, and payment becomes the responsibility of the patient or other responsible person at the time services are rendered. Please remember that an insurance policy is a contract between a subscriber and an insurance company. As a courtesy to you, we will bill a primary insurance company (and a valid Medicare supplemental carrier, if any) when we expect that the services are "covered". We require that you bring a current insurance card to each appointment, and that you inform us promptly of any change of your home address, phone number, or employment. ***Silverwood Urology*** will **not** file claims for secondary insurance benefits or for third party liability issues (including motor vehicle accidents). Fees for uncovered services, co-pays, and deductibles are the patient's responsibility, and are payable at the time of service. After primary insurance benefits are received, any remaining patient balance is due immediately. For your convenience, we will accept cash, valid checks with identification, and selected credit cards. Any check not honored by your bank will result in a $50 charge added immediately to your account. Unattended account balances older than 30 days are subject to interest charges compounded monthly at 30% APR. After 90 days, outstanding account balances will become subject to collections action and/or other legal action. *My signature below confirms that I have read and understand these policies.*

Signature: ____ Date: _______________

Patient, Parent, or Legal Guardian

White – Clinic Yellow – Patient