Arizona Center for Vasectomy and Urology
FINANCIAL POLICY

Patient Name: _____ Date of Birth: _____

Payment in full is due at the time service.
If you are unprepared to pay your copay, deductible, or coinsurance your appointment will be rescheduled.

FOR PATIENTS WITH INSURANCE We bill most insurance carriers for you if proper paperwork is provided to us. We will also bill most secondary insurance companies for you. If your insurance requires a referral it is your responsibility to assure that one is available to our office prior to or at the time of your service. If you have questions about your benefits or your insurance carrier's decision to pay or deny your claim, please contact your insurance carrier directly. If an insurance carrier has not paid within 60 days of billing, professional fees are due and payable in full from you.

MEDICARE PATIENTS We will bill Medicare for you. We will also bill secondary insurance carriers for you. All coinsurance amounts or deductibles not covered by an insurance plan are due and payable at the time service is rendered.

SURGERY FEES Copays, deductibles, and payments for non-covered surgical procedures are due prior to your surgery.

NONCOVERED SERVICES. It is your responsibility, as the insured member, to know what your insurance policy covers. Any care not paid for by your existing insurance coverage will require payment in full at the time services are provided or upon notice of insurance claim denial.

MISSED APPOINTMENTS In fairness to other patients and to the doctor, we require at least 24 hours notice to cancel appointments. You may be charged a $25.00 fee for missed appointments. If three "NO SHOW'S" we will dismiss you from our practice.

COLLECTION OF FEES
If it becomes necessary to bill you more than once for your share of services, a $5.00 per month fee will charged to your account until payment in full has been received.

In the event action is brought hereof, the prevailing party shall be entitled to recover from the other party the court costs and attorney fees as determined and awarded by the court. If this is referred for collection, I/We agree to pay collection fees. If legal action is deemed necessary, I/we agree to pay reasonable attorney's fees and court costs in addition to the above costs.

I have read, understand, and agree to the above financial policy for payment of professional fees.

_____

Signature Printed Name Date

Self-Pay Vasectomy Payment Policy
Payment in full is due at the time of service

The fee for the initial consultation visit is $75.00.
The self-pay fee for the vasectomy is $555.00, to be paid in full at the time of service.
Included: Vasectomy Procedure, surgical tray and routine medications used during procedure, post-op visit(s) within 60 days.
Semen analysis performed by the facility of our choice until the doctor has cleared the patient. Any additional surgical procedures are not included and will be billed separately.

I have read, understand and agree to the above financial policy for payment of professional fees.

_____

Signature Printed Name Date