Advanced Urologic Associates, Inc.

19001 E. 48th St South
Independence, MO 64055
816 251-5100

17525 Medical Center Parkway
Independence, MO 64057
816 251-5100

110 NE Saint Luke's Blvd #120
Lee's Summit, MO 64086
816 251-5100

Financial Agreement- Release of Information

Financial Agreement:

I agree to assign my health insurance benefits to ADVANCED UROLOGIC ASSOCIATES, INC. I agree to pay all co-payments and/or deductible amount on the day of each visit. I understand that the amount of my co-payment is determined by my insurance company and ADVANCED UROLOGIC ASSOCIATES cannot reduce the out-of-pocket amount designated by my insurance company plan. If I choose to have any service provided that is not covered by my health insurance, I understand that I will be responsible for those charges.

I understand that it is my responsibility to keep ADVANCED UROLOGIC ASSOCIATES informed of any insurance company required referrals from my primary care physician and assist in obtainment of the referrals.

I understand that if I choose to keep a visit with ADVANCED UROLOGIC ASSOCIATES without the necessary referral, I will be asked to sign a waiver form, and I will be assuming responsibility for the associated fees if my insurance company denies payment.

I understand that if I do not comply with this agreement my account will be turned over to a collection agency. I understand that I will be responsible for any collection fees and court costs associated with collection of unpaid debt I also understand that a standard $100 collection fee will be added to my account to cover the cost of collection. This fee, as well as the full dollar amount sent to collections, will be collected before I am allowed back in the practice.

I will notify the Business Office (816) 251-5100 of any changes in my address, phone number, insurance coverage or any other information that is relevant to my account. Any denials for payment as a result of my not providing the information before services are rendered will be my responsibility.

ADVANCED UROLOGIC ASSOCIATES is not responsible for the billing for any laboratory or radiology services provided by any other facility. It is my responsibility to know the requirements of my insurance.

Release of Information:

All information regarding my treatment will be held confidential and will not be released without my written consent except for treatment, payment, health care operations and communication with you from our office. My signature below indicates I have received a copy of the Patient Privacy Summary Notice and have reviewed how medical information about me may be used and disclosed.

I understand that if I wish ADVANCED UROLOGIC ASSOCIATES to file my insurance claims it will be necessary to release medical information to my carrier upon their request AND to provide all necessary filing information. I authorize ADVANCED UROLOGIC ASSOCIATES to disclose any requested information from my medical record to my insurance carrier and my referring physician for the purpose of gaining reimbursement for services rendered including information on Identification, Treatment Status, Services Supplied, Progress and Discharge Information.

I have read and understand the terms of the application above and will comply with its provisions.

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Print Patient Name

____ ____________________
Signature of Patient, Parent or Legal Guardian Date