

Adult and Pediatric Urology

Policy on Insurance Companies We Do Not Participate With

Thank you for choosing us to provide your urologic care. We are committed to the highest standards of care and the latest technologies in this rapidly advancing field. The following is a statement of our Financial Policy, which we request that you read, agree to and sign prior to any treatment.

All patients must complete our Information and Insurance Form and present insurance cards and driver's license to be photocopied before seeing the doctor.

We do not participate with your insurance carrier. We accept cash, checks, Visa, Mastercard, and American Express. All office visit amounts are due at the time of treatment.

Please be aware that some, and perhaps all, of the services provided may be "non-covered" services and not considered "reasonable" and "necessary" under your insurance coverage based on your diagnosis. We will do our best to advise you in advance of this situation. Any services non-covered by your insurance policy become your financial responsibility. The charge for broken appointments is \$25.00. The charge for canceling or rescheduling surgical procedures without 48 hours notice is \$250.00. These are not covered by your insurance carriers and thus becomes the patient's responsibility to pay.

This financial policy is to clarify any questions you may have about your financial obligation to Anshu Guleria, MD LLC. If the account becomes delinquent (not paying according to the above-stated policy), the doctor, his assigns or lawful agents may pursue collection procedures. You will be responsible for all collections costs, including and not limited to court filing fees, service of process costs, interest and attorney fees.

Thank you for understanding our Financial Policy. If you should have any questions, please ask **before** services are rendered. I have read and understand and agree to the provisions of this Financial Policy.

Signature of responsible party Date

Signature of co-responsible party Date

ASSIGNMENT OF BENEFITS

I authorize Anshu Guleria, MD LLC to request and receive information regarding my insurance coverage and benefits paid. Also, to apply for benefits on my behalf for services rendered to me and request payment from insurance company to be made directly to Anshu Guleria, MD LLC.

A copy of this authorization may be used in place of the original.

SIGNED: _____ **DATE:** _____

Signature of authorized representative of Anshu Guleria, MD LLC . & title:
