

Anshu Guleria, MD LLC.

Financial Policy for Participating Insurance Companies

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 accept cash, checks, Visa, Mastercard and American Express. All office visit co-payments and coinsurance are due at the time of treatment. Any balance on your account must be paid in full upon receipt of your statement.

****We are participating with the following insurance companies**
Medicare, Carefirst, Anthem, BC BS, Aetna, Cigna, United Healthcare,
Tricare, Humana National POS Open Access,
****Please note that this list is subject to change******

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 canceling or rescheduling surgical procedures without 48 hours notice is \$250.00. We MUST charge for appointments not rescheduled or cancelled within 24 hours notice. The charge for broken appointments is \$25.00. 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 Adult and Pediatric Urology. 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 M.D. , 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:
