UROLOGY CARE SPECIALISTS

1601 CLINT MOORE ROAD, SUITE 195
BOCA RATON, FL 33487

OUR FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bills is considered a part of your treatment. The following is a statement of our Financial Policy, which we require you read and sign prior to any treatment.

All patients must complete our information and Insurance Form before seeing the doctor. Copayments, coinsurance and deductibles are due at the time of service. We accept cash, Visa, Master card, Discover, and American Express. **We accept checks.**
Should the account not be paid, the patient assumes all cost of collection, including, but not limited to court costs, interest and legal fees.

REGARDING INSURANCE

We will accept assignment of insurance benefits, however we do require a percentage of the bill to be paid at or before the time of service when applicable. The balance is your responsibility whether or not your insurance company pays. We cannot bill your insurance company unless you provide us with complete and accurate data. Your insurance policy is a contract between you and your insurance company. We are not a part of that contract. We will facilitate the claims process by filing for you. If your insurance company has not paid your account in full within 60 days you may be responsible for the balance. Please be aware that some of the services provided may be non-covered services, not considered reasonable and necessary under the Medicare Program and other medical insurance. You will be given ABN Form per Protocol.
Exceptions to the above policy are restricted to the plans for which Dr. Schwartzwald is a contracted provider (e.g. certain HMO's & PPO's). You will be responsible for all required co-payments and deductibles at the time of service. You will also be responsible for payments for procedures not covered by your insurance company, or procedures performed for pre-existing conditions if not covered by your policy. We will assist with obtaining authorizations for all procedures, however, pre-authorizations are not a guarantee of payment by your insurance company.

USUAL AND CUSTOMARY RATES

Our practice is committed to providing the best treatment for our patients, and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates

MISSED APPOINTMENTS

Unless **cancelled at least 24 hours in advance**, our policy is to charge for missed appointments at the rate of $50.00 office visit. Please help us serve you better by keeping scheduled appointment.

_____	_____	_____
Name (Patient or responsible party)	Signature	Date

Thank you for understanding our Financial Policy. Please let us know if you have questions or concerns. I have read the Financial Policy and understand and agree to this Financial Policy.

_____	_____
Signature of patient or responsible party	Date