OUT-OF-POCKET POLICY

Patient Name: ____________________________________ Date(s) of Service: _____________________

Procedure: _______________________________________ DOB: _______________________________

Account #:____

According to your insurance company, you will have an out-of-pocket responsibility for your scheduled procedure. The portion you are responsible for includes any applicable co-pays, deductibles and percent that your insurance does not cover. (See below for breakdown of this balance).

Once your insurance company processes your claim, you will be billed for your member portion which is due 30 days after receipt. At this time, we require you to provide us with a deposit to cover that expense. This deposit can be provided either by check, cash, or credit card and will kept on file. Should your account be more than 30 days past due, your balance will be charged to your credit card and/or your cash or check will be deposited. It is important that arrangements be made and this form be completed ***prior*** to your procedure. If you fail to make arrangements, we will be unable to honor your appointment and your procedure will be canceled. If there are any questions or concerns, please contact our office at ______________________________________.

DEPOSIT DETAIL

Co-Pay: $______________________________ Deductible: $____________________________________

Amount not Covered by Insurance: $____

Total Deposit Required: $____

Please complete the information below pertaining to how you will provide your deposit

Check Check #:_________________________ Cash Amount: $______________

Credit Card: Visa Mastercard Discover

Name as it appears on the Card:____

Credit Card #: ____

Expiration Date: _______________________________________ Security Code: ________________

Cardholder Billing Address: ____

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Cardholder Signature: ____

Associated Urological Specialists, LLC is Red Flag Rules compliant as required by the Fair and Accurate Credit Transactions (FACT) Act of 2003