

Financial Information

As a courtesy to you, we will be happy to bill your insurance company for services rendered. If, for any reason, your insurance company denies the claim, you will be personally responsible for the charges. A credit card is required to be kept on file for any charges not covered by insurance. Due to the thousands of insurance plans available it is impossible for us to know the coverage details of all of the policies. It is your responsibility to know what type of coverage, benefits, deductibles, and co-payments you have with your insurance plan.

Pathology Notice: Certain tests that you have done in the office will be sent to a pathologist for diagnostic evaluation. The pathologist will submit a bill to your insurance company and bill you directly if there is a balance due.

Phone Calls: We encourage you to use the patient portal to communicate with your provider concerning health questions. Communication through the patient portal is more efficient and will allow you access to your information 24 hours a day.

Surgery Cancellation Policy: A fee of \$500.00 will be charged if you cancel a scheduled surgical procedure with less than a 10-day notice.

No Show and Late Arrival Policy: A fee of \$50.00 will be charged for "No Show" Appointments, or appointments cancelled within 24 hours of your appointment time. Subsequent occurrences may result in dismissal from the practice. If you are more than 10 minutes late, the appointment may need to be rescheduled

In-Office Procedures: In-office procedures canceled with less than 24 hours notice will incur a \$250 charge.

Assignment to Pay for Services: I agree to pay the Florida Bladder Institute for all charges for services rendered today, or on any future date of service in this office. I understand that any unpaid charges will be billed to my credit card. I further understand, in the event this account is referred to an agency or attorney for collection, I will be responsible for all collection fees, attorney's fees, and/or court costs.

I agree to receive communications via text and email.

Please Note, a 3% convenience fee will be added for all credit card transactions.

I agree with all of the statements above.

Patient Signature :

Date: