NORTH DALLAS UROLOGY ASSOCIATES

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Plano, Texas 75093
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McKinney, Texas 75093
972-548-8195 ♦ 972-548-8866 (fax)

FINANCIAL RESPONSIBILITY AGREEMENT

I, _____, understand that I am responsible for all charges incurred for my medical treatment. I consent that medical benefits from my insurance policy are paid directly to North Dallas Urology Associates, in consideration of services rendered up to the total amount of my account.

Any balance remaining after insurance benefits have been paid is my responsibility. I will pay the balance within 60 days unless other arrangements have been made. I understand that in the event of default, my account will be sent to a collection agency.

It is my responsibility to provide the correct insurance information (claims address, phone numbers, ID numbers, etc.). I will pay any balances resulting from inaccurate insurance information.

NORTH DALLAS UROLOGY will file claims with my primary and secondary insurance companies ONLY. If I have a third insurance company, I will file those claims myself. I understand that I am responsible for all remaining balances after my second insurance company has paid.

Every possible effort will be made to obtain payment for my claims. I agree to pay my account balance in the event the insurance company (ies) does not respond.

ALL COPAYS AND DEDUCTIBLES ARE DUE AT TIME OF SERVICE. I also agree to pay for in-office labs/x-rays/tests at the time of service as outlined by my insurance company.

There is a $45.00 fee for disability forms that need to be completed prior to surgery or any form requiring dictation by the doctor, and a $25.00 fee for a copy of your medical records.

It is my responsibility to obtain all referrals and to verify the in-network status of my doctor. If I do not have a proper referral, my appointment will be rescheduled until one is obtained.

I authorize the release of medical records necessary to process insurance claims.

Signature:_____ Date:_____