A blue and grey logo

Description automatically generated

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Crossroads Urology Consent for Treatment, Payment, and Financial Policy**

Our goal is to provide our patients with the highest quality care. We understand that financial matters are an important aspect of your healthcare experience. To help you understand your financial responsibilities, we have outlined our financial policy below. Please read this carefully and feel free to ask any questions you may have.

**Insurance and Billing Information**: It is the patient’s responsibility to provide us with accurate and up to date information. Please bring your insurance card to each appointment and inform us of any changes in your coverage.

**Co-payment, Deductibles, and Coinsurance**: Co-payments and remaining deductibles will be collected at the time of service. If you are unable to pay your balance in full, please contact our billing department to discuss payment arrangements.

**Self-Pay Patients**: If you are a self-pay patient, we may offer discounts for prompt payment in full at the time of service. If you would like to take advantage of this prompt pay discount, please ask.

**Non-Covered Services**: Some services may not be covered by your insurance plan. If your insurance company determines that a service is not covered, you will be responsible.

**Outstanding Balances**: All outstanding balances are due upon receipt unless you have made alternate payment arrangements with our billing department. Returned check fees and collection costs will be the responsibility of the patient.

**Cancellation and No Shows**: We require a 24-hour notice to cancel or reschedule an appointment. Patients who fail to provide adequate notice or who do not show up for their appointment may be charged a $75 no show fee. Repeated cancellations or no-shows may result in termination of care at Crossroads Urology.

**By understanding and adhering to our financial policy, we can continue to provide high-quality care to all our patients. If you have any questions or concerns about this policy do not hesitate to contact our billing department.**

I acknowledge that I have read and understand all the terms and conditions set forth in the Financial Policy, and I agree to any charges and payment terms associated with my care. I understand that Crossroads Urology agrees to bill my insurance provider as a courtesy and that I am ultimately responsible for payment of all services rendered.

I consent to the use or disclosure of my protected health information by Crossroads Urology for the purpose of diagnosing or providing treatment to me, obtaining payment for my healthcare bills, or to conduct the healthcare operations of Crossroads Urology. I understand that diagnosis or treatment by Crossroads Urology may be conditioned upon my consent as evidence by my signature on this document.

I also consent to Crossroads Urology to access my Medications and prescriptions through Surescrpits Archive.

I acknowledge that I have read and understand all the terms and conditions set forth in the Financial Policy, and I agree to any charges and payment terms associated with my care. I understand that Crossroads Urology agrees to bill my insurance provider as a courtesy and that I am ultimately responsible for payment of all *services* rendered.

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Patient Signature Date

Patient Label

If you are signing as a personal representative of the patient, please provide the following information:

Personal Representative’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Signature Date