SOUTHWEST UROLOGIC SPECIALISTS, PC

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To our patients,

Welcome to our practice. Here at Southwest Urologic Specialists we continually strive to make our office as convenient and as effective as possible for you, our patient. Therefore, we are informing you of our payment policy.

We will request a credit card to be kept on file when you check in for your appointment. This information will be secured and protected under the **Health Insurance Portability and Accountability Act** of 1996 (HIPAA). This information is obtained and secured until your insurance company has paid their portion of the services provided and has notified us of any balance owed by you (the patient). At that time, the patient responsibility portion of the balance will be charged to the card you have provided on file. You can choose to be notified of charges either by email or telephone.

Email:________________________________ **Phone:**______________________________

When you receive your EOB (Explanation of Benefits) from your insurance company, it will state the **patient responsibility** amount. You will not receive a statement from our office; your EOB will serve as notification of the amount owed by you (the patient). We also receive a copy of the same EOB from your insurance company. Thereby we are both aware of the exact amount that is remaining.

We are taking great strides to **go green** at Southwest Urologic Specialists. This will cut down on giving to generate paper statements, envelopes, mailings and you having to write a check. Our combined efforts will also help to reduce the overall cost of healthcare. **This will in no way compromise your ability to dispute charges or question what your insurance company has determined for your payment.**

We do impose a $25 administration fee if your card is declined **and** if we have to mail you a statement. However**,** this fee is waived if the card on file runs successfully allowing the bill to be paid in full **within** 30 days from receipt of the EOB. **Also, your card will not be charged without being notified prior. Do not accept American Express or Discover.**

It is the policy of our office that co-pays are collected at the time of your visit.

Thank you in advance,

Southwest Urologic Specialists, PC

☐ **Decline**

Patient Name: ________________________________

Date of Birth: ______/________/_________

Cardholder Name: ________________________

Card Number: _______/______/______/_______

Exp Date: ___________ Security Code:________

I fully authorize Southwest Urologic Specialists, PC to charge the above card for amounts I owe as determined by my insurance company as detailed in my EOB.

Cardholder's Signature:________________________________ Date:__________________