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3838 West Carson Street, Suite 220, Torrance, California 90503

FINANCIAL AND PRACTICE POLICIES

Welcome to Skyline Urology. Please take the time to review and acknowledge receipt of Skyline's financial and payment related policies.

PATIENT RESPONSIBILITY:

We will answer questions relating to your insurance to the best of our ability, however, your insurance is a contract between you and your insurance carrier. It is your responsibility to know the terms of your coverage.

We will do our best to verify your eligibility at the time of service, however you or your responsible party accept responsibility for any and all charges deemed not eligible for coverage by your insurance carrier.

COLLECTION OF CO-PAYMENTS, CO-INSURANCE & DEDUCTIBLES & CHECK-IN/REGISTRATION PROCEDURES:

Co-payments, co-insurance amounts and outstanding deductibles are collected at check-in. It is your responsibility to bring your insurance card to all appointments and to pay applicable member cost sharing amounts at the time of check in. Your appointment may be rescheduled if your insurance card and member cost-sharing amounts are not provided at the time of service. If there is a balance due after actual services rendered, you will be billed by Skyline for the outstanding amounts. Additionally, if Skyline receives an EOB (Explanation of Benefits) from your carrier that shows you have made an overpayment a refund will be issued immediately).

REFERRALS and PRE-AUTHORIZATIONS:

You as the patient/responsible party must obtain any authorization or referral required by your insurance carrier for services provided by Skyline. You understand that failure to do so could result in additional out-of-pocket expenses. Referrals MUST be present at the time of your appointment or your appointment will be rescheduled.

MEDICARE:

If you are a Medicare beneficiary, you certify that the information given by you for payment under Medicare is correct. You request that payment of authorized Medicare benefits be made payable to **Skyline Urology** for any services furnished to you by Skyline. You give permission to Skyline to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine benefits or the benefits payable for services or to obtain payment of any claims relating to these services.

MEDI-CAL:

If you are a Medi-Cal beneficiary, you certify that the information given by you for payment under Medi-cal is correct. You request that payment of authorized Medi-Cal benefits be made payable to **Skyline Urology** for any services furnished to you by Skyline. You give permission to Skyline to release to Centers for Medicare and Medi-cal Services and its agents any information needed to determine benefits or the benefits payable for services or to obtain payment of any claims relating to these services.

NO-SHOWS AND CANCELLATION POLICY:

We at Skyline Urology understand that situations arise in which you much cancel your appointment. Therefore, if you must cancel your appointment please provide more than 24 hours' notice.

Office appointments which are cancelled with less than 24 hours' notification may be subject to a $25.00 cancellation fee. Procedure/surgery cancellations require 5 – 7 business days advance notice, without notification they may be subject to a $100.00 cancellation fee.

Patients who do not show for their appointment without a call to cancel within the outlined time frame will be considered a "No Show". Patients who are a no show will be subject to a $50.00 fee for our office appointments and $150.00 fee for procedure/surgery appointments.

GUARANTEE OF PAYMENT, PERSONAL BALANCES AND RELATED FEES:

You agree to pay all applicable charges, which are not paid in full by your insurance. You understand that charges deemed as patient responsibility by your insurance carrier or not covered by your insurance carrier are your responsibility and are payable upon receipt of an invoice from Skyline. All outstanding personal balances for which the patient or responsible party have received an invoice must be paid in full prior to being seen for scheduled appointments.

Skyline will charge a $25.00 fee for all returned checks, credit card charge backs or ACH rejections (debit cards declined or charged back for non-sufficient funds). There is a monthly finance charge of 1% for accounts 30 days past due.

In the event that you default on payment of your account, you understand that you are responsible for any and all costs incurred for the collection of your account, including interest, collection fees, court costs and reasonable attorney's fees.

You also understand and acknowledge that you are responsible to pay Skyline in full for services that your health insurer will not cover due to non-payment of your health insurance premiums.

ASSIGNMENT OF BENEFITS:

You hereby request that payment of authorized Medicare/Medi-cal, and all other insurance benefits be made on your behalf to **Skyline Urology** for any services provided to you and/or your dependents by any practitioner or employee of Skyline. You give Skyline permission to submit the necessary claims to Medicare/Medi-cal or any private insurance carrier on your behalf.

AUTHORIZATION TO RELEASE INFORMATION:

You authorize release of your medical record information, pursuant to applicable federal and state laws, rules and regulations, to third party payers and other providers participating in your care. You further authorize any other individual or entity that has provided health care to you to release to **Skyline Urology** any and all of your medical record information, whether in printed or electronic form, needed to provide you with necessary care. You may revoke your consent for the release of this information at any time, except to the extent that action has been taken in reliance on this consent.

WRITTEN ACKNOWLEDGEMENT OF PRACTICE POLICIES:

You acknowledge that you have received and had an opportunity to ask questions concerning thePractice Policies of **Skyline Urology.** You agree to the terms and conditions contained herein.

Patient Signature ____________________ Date ____________________

Responsible Party ____________________ Relationship to patient ____________________