Greenwich Urological Associates Billing Policy

I am aware that it is my responsibility to provide my complete and accurate insurance and billing information, including the presentation of my most recent and up to date insurance card(s) to the Greenwich Urological Associates.

I understand that it is my responsibility to obtain a referral from my primary care physician if required by my insurance company. I understand this must be obtained prior to my scheduled appointment with Greenwich Urological Associates. If I do not have a referral on the day of my scheduled appointment and have chosen to keep my visit, I understand my insurance company may not pay for the services and therefore I will be held fully responsible for any charges incurred.

I understand that I am responsible for my paying my co-payment at the time of my visit(s). I also understand that I am responsible for any deductible or percentage of the billed service that is considered my responsibility by my insurance company after a claim has been submitted.

I understand that if my insurance company will not pay for my prescription and my physician is in agreement with an acceptable alternative, I will be given the opportunity to accept the alternative or request a prior authorization (Prior authorization's do NOT always guarantee coverage). **Should I request a prior authorization be completed by the office, I will be billed a $25.00 administrative fee for completion of this authorization. I understand that this charge is not covered under my insurance plan and I will be responsible for the payment in advance.**

We will obtain pre-certification for any radiological exams or procedures our physicians have ordered; however this does not guarantee coverage. Most insurance companies do not require pre-certification for Cystoscopy's, Prostate Ultrasounds or Ultrasound Guided Biopsies done in our office.

I understand that I will be billed $50-$150 for the following: Any missed or cancelled appointment with less than 24 hour cancellation notice, no show to an appointment or a late arrival (patient will not be seen) which makes it impossible for the physicians to maintain his or her appointment schedule.

I acknowledge that I have read and understand the billing policy.

______________________________ ____/____/____
Patient Name (Print) D.O.B.

______________________________ ____/____/____
Patient Signature DATE