

Our Financial Policy

Payment is expected at the time of service for all office visits and non-covered procedures and services. The only exception to this is services covered by Medicare, traditional Medicaid, Blue Cross and Priority Health. We accept cash, check, money order and Visa or Mastercard . **Balances carried over 90 days will be subject to a statement fee of \$20 per month.**

Insurance

We are participating providers for Medicare, traditional Medicaid, Blue Cross and Priority Health, and we will submit claims for services for these insurance companies. For all other insurance companies, we will submit courtesy claims **only** if services are paid in full on the date of service. All surgeries (except vasectomies) and hospital services are billed directly to your insurance carrier. Payment is often sent directly to the patients and should then be submitted to Bay Area Urology Associates, P.C. for payment toward your account balance. All account balances are the responsibility of the patient from the date of service.

Medicaid

Bay Area Urology Associates, P.C. are participating providers with Traditional Medicaid only (except for vasectomies) and will file all claims directly. Your signature (below) must be on file in our office in order to do this. You must also bring your Medicaid card with you to **every** appointment so that we can file your claim.

Credit Cards

As a courtesy, we gladly accept Visa and Mastercard.

Release of Information/Insurance Authorization

I hereby authorize the release of any information, including medical and billing information, by Bay Area Urology Associates, P.C., to my referring/conferring doctors, insurance company, the responsible party named on this patient information form and immediate family on behalf of myself and/or dependents. I hereby authorize Bay Area Urology Associates, P.C. to release to Medicare and its agents any information needed to determine benefits payable for related services. I hereby authorize payment of medical benefits to Bay Area Urology Associates, P.C. for services rendered to myself or dependent. I permit a copy of this authorization to be used in place of the original.

I understand and agree (regardless of my insurance status) that I am/we are ultimately responsible for the balance on my account for any professional services rendered.

Signature _____ Date _____

Patient or Responsible Party

Signature _____ Date _____

Spouse (if applicable)



Patient Information

Thank you for choosing Bay Area Urology Associates, P.C. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance.

PLEASE PRINT DATE: _____

Title	First	Middle	Last	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	
Name:					
Address:			City:	State:	Zip:
Phone #:		Work #:		Cell #:	
Date of Birth:		Social Security Number:		Family Doctor <small>First Name</small> <small>Last Name</small>	
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Dependent					
Name of Subscriber or Responsible				Subscriber Date of Birth:	
Patient/Responsible Party Employer			Spouse's Employer		
Winter Address:					
Whom may we thank for referring you to us (Doctor, Friend, Yellow Pages)?					
In case of emergency, contact:				Relation:	
Home #:		Work #:			

Responsible Party (If Minor) Parent bringing in child for appointment is responsible for payment.

Name of person responsible for this account:			Address:		
Address:		City:	State:	Zip:	
Home #:		Work #:		Employer	

Authorization

I understand that under Michigan law, an HIV test may be done on a patient if a health worker is exposed to the patient's blood or other body fluids under the worker's skin, in an open wound, or through the worker's mucous membranes. If this type of exposure occurs, then I understand that my blood can be tested without my consent. If a test is positive, I understand that I will be informed of the test results and I will receive counseling as necessary.

Signature of patient (or person authorized to sign for patient)

Date

Release of confidential medical information: Any information related to my medical care is considered confidential and will not be released to anyone without my permission. I hereby give permission for any medical information related to my case to be given to: (i.e. family/friends)

Name/Relationship _____ Phone: _____

I authorize the release of any medical information necessary to process all claims and release the payment of medical benefits to my physician:

Signature: _____ Date: _____

This form must be updated yearly, if there are any changes in your information, please request a new form. Thank you.

Initials: _____ Date: _____ Initials: _____ Date: _____ Initials: _____ Date: _____ Initials: _____ Date: _____