Urology Associates

05/07/21

UROLOGY ASSOCIATES FINANCIAL POLICY

Patient Name:_____

Patient Date of Birth;_____

I authorize any holder of medical or other information about me to release to my insurance company or the social security administration and health care financing administration any information needed for this or a related medical claim. I request payment of medical insurance benefits either to myself or Urology Associates on any bills for services furnished to me. I understand that some services are considered "non-covered" and my insurance plan will not pay for them. I will assume the responsibility for payment of any "non-covered" services.

AGREEMENT TO PAY: I, the undersigned, accept the fee charged as legal and lawful debt and agree to pay said fee including any/all collection agency fees (33.33%), attorney fees, and/or court costs is such be necessary, waiving now and forever the right to claim exemption under the constitution and laws of the state of Alabama, or any other state.

EXPRESS PRIOR CONSENT TO CONTACT CONSUMER BY CELL PHONE: You agree, in order for us to service your account or to collect monies you may owe, we and/or our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to use. Methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing device, as applicable. I/we have read this disclosure and agree that Urology Associates, its employees, and/or agents may contact me as described above.

_____ _____

SIGNATURE DATE