Summit Urology Payment Agreement

By my signature below, I am entering into an agreement with Summit Urology as follows.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures; others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or other balance not paid for by your insurance company.

In order to control your costs of billing, we request payment at the time of service.

If this account is assigned to collection and / or suit, the prevailing party shall be entitled to reasonable attorney fees, cost of collections and / or collection agency fees, to which may be added pre-judgment and / or post judgment interest at the current legal rate. One hundred and twenty (120) days after the date of service, any unpaid amounts may be assessed late payment charges of 0.5% monthly.

To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portion of the patient's record. I hereby assign all medical and / or surgical benefits under the terms of my insurance payable to: Summit Urology and / or SurgiCare.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment.

Consent to Use and Disclosure of Protected Health Information

Your protected health information will be used by this practice, known as **Summit Urology** or disclosed to others for the purpose of treatment, obtaining payment, or supporting the day to day health care operations of this practice.

We are providing you with a copy of our Notice of Privacy Practices. We request that you review the notice prior to signing this consent.

You may request a restriction on the use or disclosure of your protected health information. If you wish to restrict your disclosure, you should make the request in writing.

This practice may or may not agree to restrict the disclosure of your protected health information.

If we agree to your request, the restriction will be binding. Use or disclosure of protected health information in violation of an agreed upon restriction will be a violation of federal privacy standards. You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date of your revocation consent is received will not be affected.

This practice reserves the right to modify the privacy practices outlined in the notice.

I have received and read the Notice of Privacy Practices and have reviewed this consent form. I give my permission to this practice to use and disclose my health information in accordance with it.

Patient Name (please print)	Patient Signature	Date
Patient Representative & Relationship	Representative Signature	Date