DFW Urology Consultants

Financial Policies

As a courtesy, DFW Urology will file for your primary and secondary insurance benefits. After your policy(s) has paid you will receive a statement for any balance which is your responsibility. **Payment in full must be made within 30 days of the statement** unless payment arrangements are made with the billing office. **After 90 days your balance is subject to collections** and will be sent to our current collection agency.

You must be prepared to pay **any co-pay, co-insurance or deductible amounts due at the time of your visit**. If this is inconvenient, you may have to be rescheduled for a later date.

Your current insurance card(s) and a picture identification card must be presented at check-in at every visit.

If your policy requires a referral to see a specialist, you must be sure that DFW Urology Consultants has a copy of the current referral on or before your appointment. If your referral is not current, the appointment will be rescheduled.

If you are unable to come to a scheduled appointment, you must notify the office at 817-731-0316 at least 24 hours prior to the schedule appointment time. **Failure to meet the appointment without giving notice will result in a $50.00 No Show fee**. **Missed procedure or surgical appointments without giving notice will have a $100.00 No Show Fee.** This fee will need to be paid before you can schedule your next appointment, procedure or surgery.

Returned checks must be picked-up and paid in full upon notification from our billing office. There is a **return check processing fee of $35.00** which will be due at the time the check is picked up. The return check amount and the return fee will be added to your account and if not paid within 30 days will be subject to collections.

FMLA, Short-term Disability and other forms required by your employer will be completed within 7 working days from the date you present the forms to our office. **The fee for filling out these types of forms is $50.00.**

You may request a complete copy of your medical records. There will be a **processing fee of $25.00.**

I acknowledge that I have received, read and understand the above policies.

Name:_______________________________ Date: _________________________