Dan Hibbert Urology, PC

COMPLETING INFORMATION SHEET

1. Without the information complete you will be considered a personal pay account.
2. We need copies of your insurance card(s) for our files
3. Proper ID #'s, Social Security #'s, and names are required for the policy holder(s).
4. If retired please write "RETIRED FROM" and the company name in the employer section
5. RESPONSIBLE PARTY IS THE PERSON SIGNING THIS FORM

THANK YOU FOR YOUR COOPERATION BY PROVIDING US WITH ACCURATE INFORMATION SO WE CAN SERVE YOU BETTER AND MORE EFFICIENTLY.

WHAT WE EXPECT YOU TO KNOW ABOUT YOUR INSURANCE:

1. Insurance is usually not designed to pay the entire fee. Because insurance companies vary in the amount they will pay for various services, it is ultimately YOUR responsibility to pay the portion of the bill not paid by your insurance company (unless otherwise restricted by law or agreement we might have with your insurer)
2. AS A COURTESY we will file a claim with your insurance. (if you file your own claims, you will need to pay in full today)
3. You are responsible to call your insurance to make sure you are covered, and your services are covered, and what your co-pay is, and if the Dr is contracted.
4. We do not accept in full amounts paid by auto insurance.
5. If this is workers compensation, you need to notify the receptionist ASAP!
6. **ALL PATIENTS WITHOUT INSURANCE WILL BE CASH VISITS TO BE PAID AT THE TIME OF SERVICE. ARRANGEMENTS CAN BE MADE IN ADVANCE FOR LARGE AMOUNTS.**

THERE WILL BE A $25.00 CHARGE FOR ALL NO SHOW APPOINTMENTS AND FOR APPOINTMENTS NOT CANCELLED 24 HOURS PRIOR.

By signing below I understand this no show policy:

Responsible Party Name _____ Signature _____ Date _____

Financial Policy:

1. In accordance with the FEDERAL TRUTH-IN-LENDING ACT, all doctors are required to give their patients complete information in connection with the extension of credit.
   A) BASIC POLICY: The patient is responsible for all medical bills in our office. Our staff will help with completion of insurance forms as an accommodation and convenience to you, without charge. It is the patient's responsibility to know your contract benefits, assure collection of insurance payments to us and to negotiate with your insurance company over any disputed claims.
2. **Workman's Compensation**: In the event it is determined by the Workman's Compensation board that the illness or injury is not a result of a compensated Workman's Compensation case, I hereby agree to pay usual and customary fees for services rendered.
3. **Rejected Claims**: If your insurance company rejects your claim, policy requires you to pay the balance in full upon receipt of your statement. If you cannot pay in full, contact our Business Office.
4. **Returned Checks**: A $15.00 handling charge is applied to all returned checks.
5. **Delinquent Accounts**: Delinquent accounts over 90 days are turned over to our Collection Manager. If the bill remains unpaid and satisfactory arrangements are not made, the Collections Manager will review the account with the doctor to decide appropriate legal action. We reserve the right to add late charges for delinquent accounts requiring collection action and to add attorney's fees and court costs.
6. **Monthly Statements**: You will receive an itemized monthly statement until your bill is paid in full whether or not you have insurance. This is a courtesy to you to be aware of the status of payments on your account and have record of services. Once your insurance has paid, you are responsible for the unpaid balance. Interest of 1.15% per month (18% per year) will be applied to any amount not paid after 30 days with a minimum charge of 50¢ per month.

I have read and agree with the Financial Policy of this office.

Patient _____ Date _____

Insured _____ Witness _____

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Patient Information Sheet

Today's Date:_____

Full Name:_____ Date of Birth: _____ Age: _____ Sex: ____

Address: _____ Social Security #:_____

City, State, Zip:_____ Married:____ Single:_____ Widowed:_____ Other:_____

Home Phone#:_____ Referring Provider:_____

Alternate Phone #:_____ Primary Care Physician: _____

E-mail Address:_____

Patients Employer and Phone #:_____

Emergency Contact Name & Relationship:_____ Phone#_____

Preferred Pharmacy: _____

Responsible Party: (if same as patient write Same)

Name: _____ Date of Birth:_____ SSN:_____

Address: _____ City, State, ZIP:_____

Phone:_____ E-mail Address: _____

Employer Name and Phone #: _____

ALL CO-PAYMENTS ARE DUE AT THE TIME OF SERVICE
PLEASE COMPLETE THE INSURANCE SECTION EVEN IF COPIES HAVE BEEN MADE OF YOUR INSURANCE CARD(S)

Primary Insurance: Insurance Company Name:_____

Policy Number:_____ Group#:_____

Policy Holder:_____ Date of Birth:_____

SSN:_____ Relationship to Patient: (Circle one) Self Spouse Child Other

Insurance Address: _____ Phone #_____

Secondary Insurance: Insurance Company Name:_____

Policy Number:_____ Group#:_____

Policy Holder:_____ Date of Birth:_____

SSN:_____ Relationship to Patient: (Circle one) Self Spouse Child Other

Insurance Address: _____ Phone #_____