

FINANCIAL and OFFICE POLICIES

Dear patient:

Thank you for choosing Dr. Sheldon Freedman as your urologic healthcare provider. The following are Dr. Freedman's financial and office policies. By signing this form you acknowledge you have read and understand our policies.

Cash patients - payment is due at check-in on the day services are rendered. As a courtesy, a 25% discount will be given on charges.

Insured patients will be required to pay their co-pays, co-insurance, and deductibles at check-in on the day services are rendered. Surgery deposits must be paid prior to your scheduled surgery day, usually at the time of your pre-op appointment.

For your convenience, we accept cash, check, money order, MasterCard, VISA, Debit, and Discover Cards.

For all elective procedures, i.e. vasectomy, doppler, and penile implants, we do not accept checks. Payment must be made in one of the other acceptable forms of payment, or your procedure will be rescheduled.

A fee of \$25 will be charged to your account for any returned check.

Delinquent accounts will be turned over to a collection agency if the balance due is not received within 90 days. If your account is turned over to a collection agency, you will be responsible for all reasonable collection and court costs up to 50% of the outstanding balance at the time the account is considered delinquent.

Dr. Freedman requires a 24 hour notice for cancelled or rescheduled office appointments, and a 5 day notice for all surgical cases. If these appointments are not cancelled or rescheduled during this time frame, the following fees will apply:

\$25 office visit

\$50 office procedure (cystoscopy, prostate biopsy, vasectomy, doppler, CMG/EMG, laser)

\$200 Facility based procedure

Completion of disability forms, FMLA, Social Security or insurance forms will be assessed a \$10 fee per form to cover the administrative overhead involved with completing these forms. This is not a fee that is covered by insurance.

We appreciate your trust in us and the opportunity to serve your healthcare needs.

Patient's Signature _____

Date _____