North Atlanta Urology

Dr. Douglas Nyhoff: Dr. Howard Goldberg: Dr. Paul Rubin: Dr. Jin Yeoh

FINANCIAL POLICY

North Atlanta Urology is pleased that you have selected our practice to provide Urologic care for you. To better serve your needs and avoid confusion, it is important for you to understand our financial policy. North Atlanta Urology will process most insurance claims on behalf of our patients. We expect you to know your coverage, co-pay and/or deductible levels. North Atlanta Urology will assist you with your insurance coverage and paper work to the best of our ability if you present your current insurance information at the time of scheduling. Failure to provide us with current insurance information, you will be treated as a self -pay patient.

North Atlanta Urology bills for professional services for our physicians. Laboratory and pathology are not included as office visit fees. You will owe additional monies for these services. Many times the laboratory and pathology will be billed directly from the laboratory providing service.

Copay/coinsurance/deductibles/ self-pay: All co-pays/coinsurance/deductibles required by your insurance plan are collected at the time of service. All self-pay visit and procedure fees t due in full at the time of service.

Referrals/pre-cert/prior auth: If your insurance company requires a referral. You must obtain referral prior to scheduled appointment time. If you choose to be seen without the appropriate referral in hand, you agree to be responsible for the charges should they not be covered by your insurance.

Disputes: Should,you dispute coverage or payments made by your insurance company, you will need to resolve the matter based on your insurance company's arbitration or resolution process. We will provide documentation (providing your signature of authorization is on file) to assist in the dispute resolution process. During this time, you will be asked to pay in full the balance or schedule payment plan by contacting the Business Office at 770-995-0424.

I understand and agree that regardless of my insurance, I am ultimately responsible for the balance of my account for any services rendered. I acknowledge that I have read and understand all of the foregoing and authorize North Atlanta Urology to treat me and/or my dependants.

Patient Signature _____Date_____
Guardian or Family Member if patient is unable to sign