

# CHEYENNE UROLOGICAL, P.C.

## Financial Agreement

We bill your insurance as a courtesy. It is not a guarantee for payment nor a replacement for payment. All charges are the patient's responsibility. Any balance not paid within 30 days will be subject to finance charges. For your convenience and permission, we can keep your credit card on secure file to run every 30 days for payment. \*I, undersigned patient/guardian, agree to pay for all services rendered to me or my ward immediately upon demand. I further agree that in the event of non-payment of any amounts due under this agreement I will pay interest thereon at the rate 1.75% per month. I agree that in the event this agreement is assigned to an agency for collection, I promise to pay an additional collection fee of \$35.00 or 35% whichever is greater of the unpaid balance due. I also agree to pay all reasonable attorney fees and court cost that may be incurred.\*

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Patient Signature/Legal Representative

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Date

### DESIGNATED PERSON TO INQUIRE ABOUT STATUS OF YOUR CARE OTHER THAN YOUR PRIMARY CARE PHYSICIAN:

Due to Health Insurance Portability and Accountability Act (HIPAA), Cheyenne Urological, P.C. cannot disclose any information without patient's consent. Please designate person's information below:

(Spouse, Family Member, etc.)

I, \_\_\_\_\_ (patient name), give permission for

\_\_\_\_\_ (designated person name & phone#) to give and receive information.

( ) Please check if you **DO NOT** want anyone on file.

### PATIENT ACKNOWLEDGMENT OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION:

By signing this form, I hereby acknowledge that Cheyenne Urological, P.C. will use and disclose my protected health information (PHI) to carry out treatment, payment, and healthcare operations (TPHO). I have the right to review the Notice of Privacy Practices prior to signing this consent. Cheyenne Urological, P.C. reserves the right to revise its Notice of Privacy at any time. I may revoke this in writing to the extent that the practice hasn't already made disclosures in reliance upon my prior acknowledgment. If I choose to not sign this acknowledgment, I must pre-pay in full or Cheyenne Urological, P.C. may decline to provide treatment to me.

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Signature of Patient or Legal Guardian

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Date

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Patient Name (if different from above)

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Date

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Primary Care Provider