Payment Policy

The Patient/Parent agrees and understands they are responsible for the account, regardless of the amount the insurance company pays. The patient further agrees and understands that in the event the account is sent to a collection agency, Patient/Parent will be responsible for all collection agency fees; including reasonable attorney fees and court costs.

The Patient/Parent agrees and understands that if applicable, co-pay is due at each visit.

The Patient/Parent agrees and understands that any unpaid amounts due after 90 days is the patient's responsibility, regardless of where the insurance claim is in process.

The Patient/Parent understands that we will make all necessary attempts to collect from the insurance carrier. It is the patient's responsibility to respond to all requests for information from the insurance. After all attempts to collect from insurance are exhausted by our office, the bill will be sent to the Patient/Parent for payment.

I have read and understand the payment policy of ***Alaskan Interior Urology***

Patient Name (please print) ____

____ ____________________
Signature of Patient/responsible party Date

If you are unwilling to sign this form, payment in full is due at the time of each service.