# PAYMENT TERMS AND AGREEMENTS

I, the undersigned, in consideration for services rendered to me by Dr. Oscar A. Aguirre, MD, understand and agree to the following:

1. Any co-payments, co-insurance and deductible amounts are required to be paid on the day services are rendered.

2. Payment for charges is due on the date of service with the exception of insurance carriers for which Dr. Aguirre is under contract to file directly. Co-Payments, co-insurance and deductible amounts are due on the day of service. **Cosmetic procedures must be paid in full two weeks prior to surgery.**

3. My insurance coverage may not provide payment for all charges incurred in obtaining treatment from Dr. Aguirre. I will be responsible for any co-payment, deductible, coinsurance, or service not covered by my insurance provider. I understand Dr. Aguirre may require a credit card authorization be obtained and kept on file to be charged once each claim has been adjudicated by my insurance. However, unmet deductibles and copayments are due at time of service. If I do not have insurance coverage for services rendered by Dr. Aguirre, I agree to pay all charges resulting from such services on the day of service.

4. As a patient it is my responsibility to verify with my insurance company that Dr. Aguirre is part of my provider network (HMO, PPO, etc.). I understand it is my responsibility to obtain visit referrals from my primary care physician if my plan requires such. I understand that I am responsible for notifying the office of any changes in insurance coverage. Failure to notify Dr. Aguirre of these changes will make me responsible for claims not accepted by the insurance company.

5. I hereby authorize Dr. Aguirre to file with my insurance carrier, and I assign payment of medical benefits to Dr. Aguirre and in addition I authorize release of any and all medical records and information necessary to process any claim generated by services I receive from Dr. Aguirre.

6. I authorize release of any and all medical records and information necessary for treatment, payment and operational purposes as indicated in Dr. Aguirre's Notice of Privacy Practices.

6. Time slots for appointments, medical testing, and surgery are reserved for me alone, therefore any cancellation of such with less than adequate notice to the office creates a hardship. Therefore, I agree to be responsible for the following cancellation/"no-show" fees with the times as noted. Less than two business days' notice or "no-show" for my appointment: **office appointments $50, *cosmetic appointment $100, cystoscopy $75, urodynamic testing $100, PNE $200.00. The cancellation fee for strictly urogynecologic surgeries cancelled for non-medical reasons within 15-30 days is $50, 4-14 days is $100, and less than 72 hours' notice is $500**. I understand these fees are not covered by insurance and are my responsibility and will be due at the time of cancellation of appointment or billed immediately after no-show for my appointment... (Please refer to separate policy for cosmetic procedures or combination cosmetic and urogynecologic procedures).

7. Non-covered elective procedures must be paid in full prior to treatments being performed. Our office will not bill non-covered elective procedures to your insurance company. Elective procedures include but are not limited to; BioIdentical Hormone Replacement Therapy, cosmetic surgery, vaginal rejuvenation procedures.

8. Returned checks will incur a $ 35.00 fee and accounts turned to collection will be charged a collection fee.

9. There is a $25 charge for each disability, FMLA, or other medical form to be completed. We require 7 days for completion. Expedited (1 business day) service is available for $50 per form. Payment must be received prior to the completion of the forms.

### CONSENT FOR TREATMENT

I, the undersigned, voluntarily agree to the tests, procedures, and/or treatments which the physician has deemed necessary and which are administered to or performed on me under the direction of the physician or his/her designee.

### CONSENT TO RELEASE MEDICAL RECORDS

1. I understand that my insurance carrier may require copies of my medical records in order to process claims. I hereby agree to such release of my records.

2. I understand that in the course of its own business Dr. Aguirre's staff members will have access to my medical record. I hereby agree to such sharing of my personal health information.

### CONSENT TO COMMUNICATE MEDICAL RESULTS

If you are not home, may Dr. Aguirre leave non-critical laboratory results as well as appointment reminders on your home voice mail/answering machine?

Yes ___ No ___

Persons with whom Dr. Aguirre and/or staff may discuss my medical condition (other than for purposes of treatment, payment or operations):

Name:_____________________________________________ Name:________________________________________________

Name:____________________________________________ Name:________________________________________________

**Signature:** ___________________________________________________________ **Date:** ____________________________________

**A photocopy of these assignments shall be as valid as the original**