CHEYENNE UROLOGICAL, P.C. **ACCOUNT#________________**

Office Payment Policy: With each balance billed after your insurance has processed, a payment plan will be assessed in the following way.

* $0-$75.00	-----	Bill must be paid in full within 30 days
$76.00-$300.00	-----	$75.00 minimum payment every 30 days
$301.00-$1000.00	-----	$100.00 minimum payment every 30 days
$1000.00 or more	-----	$250.00 minimum payment every 30 days

* Any balance not paid in full within 30 days will be subject to finance charges. For you convenience and permission, we can keep your credit card on secure file to run every 30 days for payment.
* I, the undersigned client/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% which ever is greater of the unpaid balance due. I also agree to pay all reasonable attorney fees and court cost that may be incurred.

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

Due to Health Insurance Portability and Accountability Act (HIPPA), Cheyenne Urological, P.C. cannot disclose any information without patient's authorization.
Please designate person's information below: (Like Spouse, Family Member, Ect.
I,________________________________(Patient Name), give permission for (Designated Person Name and Phone Number)____to give and receive information.
( ) Please check if you DO NOT want anyone on file.

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION:

I hereby give my consent for Cheyenne Urological, P.C. to use and disclosure protected health information (PHI) about me 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 it Notice of Privacy at anytime.
By signing this form, I am consenting Cheyenne Urological, P.C. to use and disclose my PHI to carry out TPHO.
I may revoke my consent in writing to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent Cheyenne Urological, P.C. may decline to provide treatment to me.

____ _____________________________

Signature of Patient or Legal Guardian Date

____ _____________________________

Patient's Name Date of Birth