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.

_____ _____

Patient Signature/Legal Representative Date

DESIGNATED PERSON TO INQUIRTE 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:
(like 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 CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION:

I hereby give consent for Cheyenne Urological, P.C. to use and disclose 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 any time.
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 choose to not sign this consent, I must pre-pay in full or Cheyenne Urological, P.C. may decline to provide treatment to me.

_____ _____

Signature of Patient or Legal Guardian Date

_____ _____

Patient Name (if different from above) Date