**STAR UROLOGY OF TEXAS – STATEMENT OF POLICY**

As a new or established patient of Star Urology of Texas, I am aware of the following regarding my insurance coverage.

**I** understand as a managed care patient that my insurance policy is a contract between myself and my insurance company and that it is my responsibility to:

* Provide our office with accurate insurance information each visit including, but not limited to:
* Insurance cards
* Picture identification
* Other documentation that will aide insurance processing
* Bring my insurance card each visit and present to the receptionist
* Voluntarily update insurance information each visit at check-in time
* Disclose and pay any deductibles, co-pays and patient due amounts at the time of services
* Pay at the time of services if proper insurance documentation cannot be presented at the time of visit

No refunds or adjustment amounts will be refunded at a later date. I will be responsible for filing of any insurance claims.

* Pay any balance not paid by the insurance after adjustments within 30 days of notification by means of a statement, letter or other means of communication
* If my insurance does not pay for the visit within a reasonable time, the balance will be my responsibility (exception: inaccurately filed claims)
* Be aware of my plan provisions regarding:
* Referrals
* Outpatient procedures (preformed in the office or an outpatient facility)
* Non covered services
* Pay for any non-covered services under my policy either at the time of service or as soon as reimbursement if denied.

**Star Urology of Texas, P.A.** has qualified, experienced staff that can assist you with many of your insurance problems, but because of the volume of different insurance plans we are unable to be familiar with all the aspects of each plan. It is our goal to provide you with the best medical care available while being sensitive to the provisions of your insurance policy.

I have read and understand the foregoing information.

**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

* **Patient Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient’s S.S. #\_\_\_\_\_\_\_\_-\_\_\_\_\_\_-\_\_\_\_\_\_ Patient’s Account #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**