

**UROLOGY ASSOCIATES  
OF  
NORTHEAST FLORIDA, P.A.**

**DIPLOMATE, AMERICAN BOARD OF UROLOGY  
MARC H. BLASSER, M.D.  
CHRIS D. MOORE, M.D.  
JAMES E. KAELIN, M.D. RETIRED  
DAVID W. FORBIS, RN, PA-C  
MARY K. SCHUPP, MSN, ARNP**

**FINANCIAL POLICY**

OUR OFFICE POLICY IS THAT FEES ARE DUE WHEN SERVICES ARE RENDERED.

*WE MUST EMPHASIZE THAT AS YOUR HEALTHCARE PROVIDERS, OUR RELATIONSHIP AND CONCERN IS WITH YOU AND YOUR HEALTH, NOT YOUR INSURANCE COMPANY.*

WE WILL GLADLY DISCUSS THE COST OF YOUR VISIT AND DO OUR BEST TO ANSWER ANY QUESTIONS RELATING TO YOUR INSURANCE COVERAGE. HOWEVER, YOU MUST REALIZE THE FOLLOWING:

- YOUR INSURANCE IS A CONTRACT BETWEEN YOU, YOUR EMPLOYER, AND THE INSURANCE COMPANY. WE ARE NOT PARTY TO THAT CONTRACT. YOU ARE ULTIMATELY RESPONSIBLE TO KNOW WHAT YOUR POLICY PROVISIONS ARE AT THE TIME OF SERVICE.
- IF YOU HAVE INSURANCE AND WOULD LIKE US TO FILE THE CLAIMS FOR YOU, YOU MUST PROVIDE ACCURATE INFORMATION AND PRESENT ANY FORMS OR ID CARDS TO THE RECEPTIONIST PRIOR TO YOUR VISIT. IT IS ALSO YOUR RESPONSIBILITY TO OBTAIN A CURRENT REFERRAL FOR YOUR OFFICE VISIT AND IF YOU FAIL TO DO SO YOU WILL BE RESPONSIBLE FOR ALL CHARGES INCURRED.
- **YOU ARE RESPONSIBLE FOR THE BALANCE OF CLAIMS THAT ARE NOT PAID WITHIN 90 DAYS IT IS UP TO YOU TO CONTACT YOUR INSURANCE COMPANY FOR PAYMENT.**

I DO HEREBY AGREE TO PAY ANY AMOUNT THAT MY INSURANCE REFUSES AND THAT I WILL BE HELD RESPONSIBLE FOR THE BALANCE OF MY ACCOUNT. I AUTHORIZE PAYMENT OF INSURANCE BENEFITS RESULTING FROM MY CARE IN THIS OFFICE TO UROLOGY ASSOCIATES OF NORTHEAST FLORIDA, DRs. KAELIN, BEARSS, AND BLASSER.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_