The Urology Clinic of Utah Valley

PRIVATE PAY POLICY

I _____, (the patient or responsible party) acknowledge that I am responsible to pay $100.00 before seeing the doctor. This payment may or may not represent my total bill for the services rendered. At the conclusion of my visit, it is my responsibility to obtain my total bill. If the cost of the visit is less, it is my responsibility to request a refund. If the cost is more it is my responsibility to either pay the remaining balance of set up arrangements for future payment. If I pay the amount in full the day of my visit I will receive a 10% discount. If I cannot pay the amount in full I am responsible to set up a payment plan with the billing department before I leave. The payment plan will require that I pay the amount in full over a three month period.

If a procedure or surgery is required I need to talk to the billing department before I leave the office to see how much the visit will cost and to then set up a payment plan.

If I do not pay for my visit in full or set up a payment plan before leaving the office, I will be responsible to pay the amount in full when I receive my first statement.

***If I do not pay the amount when it is due my account will be sent to a collection agency and I will not be able to be seen in this office again.**

***No payment plans will be set up after I leave the office. It is my responsibility to take care of my account before I leave.**

_____ _____

By signing I agree to the terms above Date

_____ _____

Authorized Signature Date