



UROLOGY SPECIALISTS

OF MILFORD, LLC

Jeffrey Steinberg, M.D.

Dear Patient:

We would like to take this opportunity to welcome you to our practice. We look forward to meeting you and providing the highest quality urologic care.

We have scheduled an appointment for you with Dr. Steinberg on:

\_\_\_\_\_ at : \_\_\_\_\_.

Please plan to arrive at the office 15 minutes before your scheduled appointment.

To facilitate your appointment, we ask that you please take a few moments to read and complete the enclosed New Patient Information and forms. By doing this prior to your office visit, we hope to make your visit as efficient as possible.

If your insurance requires a referral or preauthorization when seeing a specialist, please contact your primary care physician as soon as possible and confirm this has been completed prior to your appointment with us.

Please bring the following items to your appointment:

All Completed Forms

Insurance Cards

Driver's License or Picture ID

Insurance Copay and Coinsurance

A credit card you would like to use to save on file with us

List of medications and allergies

We appreciate your time in helping us to streamline your visit and serve you as efficiently as possible.

If you have any questions or need any assistance, please call our office. We will be happy to help you in any way we can.

We are looking forward to meeting you.

Sincerely,

Sue Lavalley  
Office Manager  
Urology Specialists of Milford

18 Asylum Street, Milford, MA 01757 **P** 508-473-6333 **F** 508-634-0570 [urologyspecialistsofmilford.com](http://urologyspecialistsofmilford.com)

Excellence. Experience. Compassion.



UROLOGY SPECIALISTS

OF MILFORD, LLC

Jeffrey Steinberg, M.D.

## 2021 STATEMENT OF FINANCIAL POLICY **IMPORTANT HIGHLIGHTS**

Recent changes in health insurance plans have required us to update our financial policies. Please read the following information carefully as these updates to our financial policy may impact how we collect your patient responsibility at office appointments and for hospital surgical procedures. Please refer to our Certification and Authorization of Financial Policies for more information.

### **I. Urology Specialists of Milford requires your patient responsibility amount to be paid at the time of your visit.**

Prior to your Office visit, our staff will review your insurance benefits and determine if you will be responsible for any co-payment, co-insurance, or deductible for your visit. The amount you will be required to pay will be estimated based upon the information provided to us by your insurance company. Any overpayment made by you will be promptly refunded to you by Urology Specialists of Milford, and you will be billed by Urology Specialists of Milford for any additional balance the insurance company may determine you owe.

### **II. Urology Specialists of Milford requires all prior account balances to be paid at the time of your visit.**

Prior to your Office visit, we will notify you by phone if you have a current or past due balance on your account. At your Office visit, we will collect payment for all account balances. Additionally, if you have an outstanding insurance claim that has not yet been adjudicated, we reserve the right to estimate your patient responsibility for that visit and collect payment at your office visit or prior to your surgery.

### **III. Urology Specialists of Milford requires payment for your patient responsibility amount prior to all Hospital Surgical Procedures and certain Office Procedures.**

Prior to your Office visit, our staff will review your insurance benefits and determine if you will be responsible for any co-payment, co-insurance, or deductible for your Hospital Surgical or Office Procedure. The amount you will be required to pay will be estimated based upon the information provided to us by your insurance company. Any overpayment made by you will be promptly refunded to you by Urology Specialists of Milford, and you will be billed by Urology Specialists of Milford for any additional balance the insurance company may determine you owe.

### **IV. Urology Specialists of Milford requires patients to save a credit card on file at the time of your visit.**

We use PHREESIA, a leading Healthcare Payments network, to securely save your encrypted credit card information, and to process any overdue payment at a later date or set up a payment plan for you. If you do not pay your patient responsibility amount or set up a payment plan with the office within 45 days of your date of service, we will charge to your saved credit card the amount you owe. If your saved credit card is or has been declined, or if you refuse or are unable to save a credit card on file with us, we will ask you to pay your patient financial responsibility at the time of service.



UROLOGY SPECIALISTS

OF MILFORD, LLC

Jeffrey Steinberg, M.D.

## PATIENT'S CERTIFICATION AND AUTHORIZATION FOR FINANCIAL RESPONSIBILITY

**PLEASE CAREFULLY READ THE HIGHLIGHTED INFORMATION BELOW REGARDING HOW WE COLLECT YOUR PATIENT RESPONSIBILITY. THANK YOU.**

### DISCLOSURE:

Urology Specialists of Milford, LLC is a for-profit professional limited liability corporation solely owned and providing medical services to the community.

I hereby assign to Urology Specialists of Milford, LLC all payments to which I am entitled for medical and/or surgical benefits, relative to the services provided. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance, and any other health/medical plan to issue payment directly to Urology Specialists of Milford, LLC for all medical and/or surgical services rendered to myself and/or my dependents, regardless of insurance benefits, if any, and I understand I am responsible for any amount not covered by insurance.

I hereby authorize Urology Specialists of Milford, LLC to release any information necessary to my insurance carrier regarding my or my dependent's diagnosis, treatment, illness or injury in order to process my claims, secure payment, or for treatment and healthcare operations, and I allow a photocopy of my signature to be used to process insurance claims for the period of lifetime.

I agree to respond to any additional information that the insurance company may request in a timely manner. I understand that if the payment of any claim is delayed more than 90 days from the date of service, Urology Specialists of Milford, LLC reserves the right to collect the balance from me.

**I understand that I am fully financially responsible for any and all charges incurred for the course of treatment authorized, and all account balances, co-payments, co-insurance, deductibles, and charges for items not covered by my insurance are payable on the date services are rendered. If I have an outstanding insurance claim that has not yet been adjudicated, I understand that Urology Specialists of Milford, LLC may estimate my patient responsibility for that visit and collect payment at the office visit or prior to surgery.**

**I understand that Urology Specialists of Milford, LLC requires a credit card to be saved on file. I hereby authorize Urology Specialists of Milford to save my credit card on file for future payment of all my patient financial responsibility balances, including any payments or payment plans that I authorize. I further authorize Urology Specialists of Milford to charge the amount owed to my saved credit card on file if I do not pay my patient responsibility balance within 45 days after the date of service. I understand that I may direct Urology Specialists of Milford to process payments using my saved card on file at any time.**

**I also understand that I will be required to pay my patient responsibility on the date of service if I refuse to save a credit card on file, if my account is or has been delinquent, or if my saved credit card is declined.**

**I consent to be contacted by Urology Specialists of Milford by phone, text, email or mail regarding any financial or payment information related to my account. I understand that a copy of my payment receipt will be sent to me by email after any transaction is processed.**

**I understand that Urology Specialists of Milford, LLC requires my financial responsibility to be paid prior to all Hospital Surgical Procedures, and certain Office Procedures. The amount I will be required to pay will be estimated based on my insurance plan and will include all deductibles, copays, and coinsurance. Any overpayments will be promptly refunded to me by Urology Specialists of Milford.**

I understand that it is my responsibility to secure referrals and all necessary authorizations under the guidelines of my insurance policy. I understand that certain lab tests may be sent to an outside laboratory that is not affiliated with this practice and I will be billed separately by the laboratory.

I understand that there is an additional charge of \$25.00 for any check that is returned by my bank for any reason, and unpaid checks will be reported to the MA Attorney General's office. Delinquent accounts may be listed with local and national credit bureaus.

A photocopy of this assignment is to be considered as valid as the original. This consent shall remain in effect until I give Urology Specialists of Milford written notification of its termination. I further understand that this policy in no way limits my ability to dispute a charge or question my insurance company's determination of payment.

\_\_\_\_\_  
Patient Name (Printed)

\_\_\_\_\_  
Date of Birth

X \_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date of Signature

18 Asylum Street, Milford, MA 01757 **P** 508-473-6333 **F** 508-634-0570 [urologyspecialistsofmilford.com](http://urologyspecialistsofmilford.com)

**Excellence. Experience. Compassion.**



UROLOGY SPECIALISTS

OF MILFORD, LLC

Jeffrey Steinberg, M.D.

CONSENT TO USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

USE AND DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION (PHI)

Your protected health information, including all medical records and entire patient file, will be used by Urology Specialists of Milford, LLC or disclosed to others for the purposes of diagnosing or providing treatment, obtaining payment for all healthcare services, or supporting the day-to-day health care operations of the practice, including billing, administration, laboratory and diagnostic centers. For a complete description of how your protected health information (PHI) may be used or disclosed, please review and read Urology Specialists of Milford LLC's Notice of Privacy Practices.

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have read and reviewed the Notice of Privacy Practices and Patients' Rights pertaining to this office and its affiliated covered entities, and all my questions have been answered to my satisfaction. I understand that I can ask for a copy of this notice at any time and the office will provide it to me upon request.

RESERVATION OF RIGHT TO CHANGE PRIVACY PRACTICES

Urology Specialists of Milford, LLC reserves the right to modify the privacy practices outlined in its Notice of Privacy Practices.

REQUESTING A RESTRICTION ON THE USE OR DISCLOSURE OF YOUR INFORMATION

You may request a restriction on the use or disclosure of your protected health information.

Urology Specialists of Milford, LLC may or may not agree to restrict the use or disclosure of your protected health information. If Urology Specialists of Milford, LLC agrees to your request, the restriction will be binding on the Practice. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

RIGHT TO TERMINATE OR REVOKE AUTHORIZATION

You may revoke or terminate this authorization by submitting a written revocation to the Practice Manager at Urology Specialists of Milford, LLC.

I have reviewed this consent form and give my permission to Urology Specialists of Milford, LLC to use and disclose my health information in accordance with the terms specified above.

Name of Patient (Print) Date of Birth

X Patient Signature Date of Signature

Signature of Patient Representative Relationship of Patient Representative to Patient



UROLOGY SPECIALISTS  
OF MILFORD, LLC

Jeffrey Steinberg, M.D.

**PATIENT REGISTRATION**

Last Name \_\_\_\_\_ FirstName \_\_\_\_\_ M.I. \_\_\_\_\_  
StreetAddress \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZipCode \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Birthdate \_\_\_\_\_ Email \_\_\_\_\_  
Referring Physician \_\_\_\_\_ Phone \_\_\_\_\_  
Primary Care Physician \_\_\_\_\_ Phone \_\_\_\_\_  
Pharmacy \_\_\_\_\_ Phone \_\_\_\_\_

**CONSENT FOR RELEASE OF MEDICAL INFORMATION**

\_\_\_\_\_ Initials I hereby authorize Urology Specialists of Milford, LLC to release my protected health information, appointment reminders, account balances and financial information to my immediate family members, care giver, pharmacist and any physician who participates in my care.  
  
\_\_\_\_\_ Initials I hereby authorize Urology Specialists of Milford, LLC to leave messages on my answering machine or voicemail regarding my protected health information, appointment reminders, account balances and financial information.

**ADDITIONAL PERSONS TO WHOM INFORMATION MAY BE DISCLOSED**

Please list below any individuals you wish to have access to your protected health information:

1. \_\_\_\_\_  
Name \_\_\_\_\_ Date \_\_\_\_\_ Patient's Initials \_\_\_\_\_  
2. \_\_\_\_\_  
Name \_\_\_\_\_ Date \_\_\_\_\_ Patient's Initials \_\_\_\_\_

**CONTACT IN CASE OF EMERGENCY**

Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

**This consent shall remain in effect until I give Urology Specialists of Milford written notification of its termination.**

\_\_\_\_\_  
Printed Name of Patient Signature of Patient Date

