Andrew L. Simon M.D., F.A.C.S.
Diplomate, American Board of Urology
Urology and Genitourinary Surgery
459 Jack Martin Boulevard Suite 3
Brick, New Jersey 08724
732-840-0900

Financial Policy (updated 7/21/22)

We are committed to providing the best medical care possible. Please understand that payment of your bill is considered a part of your treatment. The following statement explains our policy.

It is important for you to understand that your health insurance coverage is an agreement between you and your insurance company. Your doctor's bill for the services provided to you is an agreement between you and your Doctor. **You are personally liable for all balances not covered by your insurance.**

Our time as well as your time is valuable and if you have an appointment with us we ask that you cancel **24 hours prior** if not you may be charged a **$50.00 Cancellation/No Show fee.**

Payment in full is expected at time of service unless you are covered by an insurance carrier in which Dr. Simon is considered a participating provider. You are responsible for **deductibles, co-pays**,non-covered services, **co-insurance,** and items considered non medically necessary by your insurance company as well as other charges you may incur for services rendered by us. It is your responsibility to understand and comply with all the terms of your insurance contract including predetermination of benefits or **referral requirement**.

Co-Payments: Payment for all copays (primary and secondary insurances) is expected at the time of service. No exceptions. If you do not have your copay you will be rescheduled.

Returned Checks: A $35.00 fee will be charged for all checks that are returned for non-payment.

Referrals: It is the patient's responsibility to know if your insurance plan requires a referral for our services and to obtain the referral prior to the time of service. If a referral is not presented at the time of service , the patient will either be rescheduled or will be responsible for payment in full for that service at the time of service.

Insurance: As a courtesy, we will submit your claim to your secondary carrier if it does not cross over from your primary insurance. **(WE DO NOT BILL THIRD INSURANCE!)**

Past Due Accounts: I agree to be financially responsible for the charges for these services. If my account is assigned to Savit Collection Agency, I agree to pay a collection fee of 25%, court costs and reasonable attorney fees.

Communications with you and Consent to Contact You: By providing a wired and/or wireless telephone number you agree,in order for us to service your account or to collect any amounts you may owe, we, our agents,assignees, third-party(s) servicing agents or a third-party debt collector may contact you by telephone at any telephone number associated with your account. You also agree to allow us ,our agents,third-party(s),servicing agent or Savit Collection Agency to communicate with you to include text messaging,email, fax and any other electronic communications. You also agree that methods of contact may include the use of pre-recorded/artificial voice messages and/or use of an automated telephone dialing device or service, as applicable. You agree that we, our agents,assignees,third-party(s) and Savit Collection Agency may , for training purposes or to evaluate the quality of service, may listen to and record phone conversations you have with us.

We Accept Cash, Checks, Money Orders and Visa or Mastercard. (Credit Card Minimum $10.00)

I have read the Financial Policy , Assignment and Release of Information paragraphs stated above. I understand and agree to the above.

Print Name	Signature	Date

A COPY OF THIS NOTICE WILL BE FURNISHED UPON REQUEST