UROLOGY ASSOCIATES OF CONNECTICUT

J. JAMES BRUNO, II, M.D., F.A.C.S
STANFORD R. BRODER, M.D., F.A.C.S.
GUY J. MANETTI, M.D., F.A.C.S.
ALEX M. HENNESSEY, M.D., F.A.C.S
EDWARD M. BECK, M.D., F.A.C.S.
GIL A. WEIZER, M.D., F.A.C.S.

MICHAEL E. GOLTZMAN, M.D.
ANDREA H. RUSSO, M.D., F.A.C.O.G.
DIANE ST. PIERRE, M.H.S., P.A.C.
AMANDA G. MADKOUR, M.S., P.A.C.
MARY VALENTINO, APRN
LISSETTE RIVAS SIRACUSA, APRN

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I received a copy of the Notice of Privacy Practices. I further acknowledge that a copy of the current notice is posted in the reception area, and that I may request a copy of any amended Notice of Privacy Practices at each appointment.

Financial Policy

Insurance:
We have agreements with many insurance plans to accept an assignment of benefits. We will bill those plans with whom we have an agreement and will require you to pay co-payment and unmet deductible/coinsurance at the time of service. Patient will be responsible for any non-covered services.

Patients with insurance plans that we ***do not*** have agreements with may see us and will be charged according to our discounted fee schedule. If you have out of network benefits, we are happy to provide a claim form that you may submit to your carrier for reimbursement.

Letters/Form completion:
At the discretion of the physician, letters and forms requiring medical review and physician signature are subject to a $25.00 fee per form.

Referrals:
If your insurance company requires a referral to see a specialist, you are responsible for obtaining the referral. If the referral is not processed BEFORE your visit you will need to reschedule.

Cancellation/No Show Policy:
Your appointment time is reserved for you with your provider. PLEASE be aware that our policy states that proper notification of 48 hours is expected. A $50.00 fee will be charged per missed office visit. Vasectomy, Botox, Penile Doppler Ultrasounds, and Urodynamic Study appointments require a $200.00 deposit. If you do not cancel the appointment within 48 hours, not including weekends and holidays, the deposit will NOT be refunded.

Insurance Authorization:
I have read and understand the financial policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice. I hereby authorize Urology Associates, P.C. to furnish information to insurance carriers concerning my illness and treatment.

_____ _____
Signature of Patient Date

_____
Please Print the Name of the Patient Date: 04/17/2025