Vasectomy Reversal Financial Agreement

UROLOGY SAN ANTONIO

I understand the service(s) listed below are considered elective procedure(s) by Urology San Antonio and will not be billed to my insurance. I agree to pay the following in full before the procedure is scheduled.

Procedure		Price	Amount Due	Paid Date
□ Consult Visit (99203)	$210*	$_____	_____	_____
□ Vasovasostomy (55400)	$6,900**	$_____	_____	_____
□ Vasoepididymostomy (54901)	$2,000†	$_____	_____	_____
	Total	$_____	_____	_____

_____ _____
Patient Name (Printed) Patient Date of Birth

_____ _____
Patient Signature Patient Email Address

* Amount will be refunded if procedure (55400) is completed within 3 months of consult visit.
** If procedure (55400) should be stopped for any reason, patient will be refunded $1,000.
† If procedure (54901) is not performed, patient will be refunded full amount

Submit This Agreement

Full payment for elective service(s) is due before the procedure is scheduled. Please submit this signed agreement by Fax: (210) 679-3720 or Email: payment.posting@urologysa.com. Once received, a representative will call you to process total payment for services and send a receipt. You may also make a payment by visiting www.urologysantonio.com/payments.

Questions?

If you have any questions regarding the billing and payment process, please call (210) 731-2050 ext. 6205.

Cancellation Policy

If you must cancel your procedure, please call your surgery scheduler and confirm cancelation at least 72 hours prior to your scheduled surgery. No refund will be provided if the procedure is canceled with less than a 72 hour notice.

Urology San Antonio Use Only

PREPAYMENT:
□ Credit Card – ending in _____(last 4 digits)
□ Personal Check #_____
□ Cash iSalus Receipt date_____

USA Representative Name (Printed):_____ Date:_____