John M Cannon, MD
Urology and Urologic Surgery
1770 Long Pond Road, Suite 101
Rochester, NY 14606
Telephone (585)244-8110
Fax (585)244-9435
www.cannonurology.com

Policies and Procedures

Please read each section of our office policy and initial.

____________ Appointments:

1. Appointments are booked on first come-first served basis. Patients are responsible for their appointment to keep or reschedule as needed.
2. We understand that calendars can get busy. As a courtesy, we have dedicated staff to make reminder phone calls/texts to the designated phone number within 7-10 days of upcoming appointments.
3. Your appointment is your time with Dr. Cannon. You do not see a PA or NP. To honor Dr. Cannon's commitment we require a minimum 24 hour notice of cancellation. Please be aware that there is a $40 fee for a missed appointment.
4. We strive to minimize any wait time; however, the doctor uses his discretion with each patient to give the time that is needed for appropriate evaluation and counsel.
5. To limit your office time, you can access www.cannonurology.com, "*information and forms*" and print patient registration forms as needed.

____________ Insurance Plans:

1. It is your responsibility to know what your insurance coverage is and that we are in network with your plan. It is also your responsibility to understand what may or may not be covered by your plan and at what percent coverage. Our staff is not responsible for understanding your insurance policy, its coverage and/or limitations. Any questions regarding your specific coverage should be answered by your insurance company directly.
2. It is your responsibility to know if a written referral or authorization is required to see a specialist, whether pre-authorization is required prior to a procedure, and what services are covered. Check with your insurer prior to making these appointments.
3. If you have a high-deductible plan, we will require your payment at the visit per the plan and submit the claim to your insurance to be applied to your deductible.

____________ Prescription refills:

1. Call your pharmacy and ask that a refill request be sent to our office.
2. We require 72 hours notice (3 business days) to process prescription refills. Please plan accordingly as renewals and refills are handled Monday through Friday between 8:30 am and 4:30 pm.
3. Please bring your medication list to your appointments so we can update records accordingly.

(Continued on next page)

John M Cannon, MD
Urology and Urologic Surgery
1770 Long Pond Road, Suite 101
Rochester, NY 14606
Telephone (585)244-8110
Fax (585)244-9435
www.cannonurology.com

Policies and Procedures (continued)

__________ Financial and Billing:

1. Payment for medical treatment is **due at the time of service**. Cash, Check, Visa, Master-card, and Discover are accepted forms of payment. A $10 charge is assessed for unneces-sary billing.
2. **Co-payments are due at the time of service**. Please plan accordingly.
3. Patients with **high-deductible health plans are responsible to pay in FULL at time of visit** until the deductible has been met.
4. **Self-pay patients are expected to pay for service in FULL at the time of the visit** un-less prior arrangements have been made.
5. If the patient has medical insurance coverage, a claim will be sent to the patient's insur-ance company. If there is a balance after insurance payment, the patient will then be re-sponsible for the balance and billed accordingly.
6. Patient balances are billed monthly after receipt of your insurance plan's explanation of benefits. Your remittance is due within 3 weeks of the receipt of your bill.
7. If previous arrangements have not been made with our billing office, any account balance outstanding longer than 45 days may incur a $5 service fee. For patients with insurance coverage, this 45 day time-frame will begin from the date your insurance has paid and the patient's balance is known.
8. Outstanding balances must be paid prior to your next scheduled appointment.

By signing this policy …

- *I authorize direct payment to the practice of Dr. John M Cannon of all applicable medical bene-fits to me/my family member under the terms of my/their current health insurance. A copy of this authorization is deemed effective and valid as the original.*

- *I agree that I am financially responsible for all charges whether or not paid for by insurance. This to include any collections, billing, and/or attorney fees and disbursements as incurred for the collection of my financial obligations for services rendered.*

- *I authorize the release of any medical information necessary to process insurance claims and/or to comply with my health plan audit requirements. This includes sensitive information such as HIV-related, substance abuse diagnosis and treatment and mental health related care etc.*

- *I agree to the above terms and will notify the office of Dr. John M Cannon of any changes.*

Signature/Guarantor ______________________________ Date ___________

Print Name/Guarantor ______________________________