SOUTHLAND UROLOGY

Adult and Pediatric Urology

301 W. Bastanchury Rd.
Suite 180
Fullerton, CA 92835

16960 E. Bastanchury Rd.
Suite F
Yorba Linda, CA 92886

Day or Night Call: (714) 870-5970

Some Important Reminders:

1. Please have all your insurance cards and forms of ID (State issued or military ID) for your appointment. It is your responsibility to verify that we are contracted with your insurance **(We will not see you if you do not have your insurance cards or form of ID.)** As a reminder, we are not preferred providers for the following insurances:

AETNA PPO ONE HEALTH PPO ASSURANT PPO

COVERED CALIFORNIA/BLUE CROSS PATHWAY

We will continue to see patients who have the aforementioned insurances. We will be happy to bill your insurance, but you have a higher deductible and/or out-of-pocket expense. It is possible that you may not have any out of network benefits and the total bill would be your responsibility. If you have any questions about your coverage and/or benefits, **please call your insurance** and inquire about out of network benefits.

2. Please complete all paperwork. **(If your paperwork is not completed, it could delay your appointment or your appointment may be canceled.)**

3. If you had any recent radiology tests or blood work please inform the front office. If you have had any radiology tests please bring your films with you, unless they were done at St Jude, to your visit.

Appointment Cancellation Acknowledgment

Please be advised that there may be up to a **$75.00** charge for any no-show appointments. Any appointment, including surgery, that is canceled or rescheduled fewer than **2 business days** in advance **may** also be charged up to **$75.00**.

The no-show/cancellation fee will be billed directly to you and not your insurance company, as we require **2 business days** notice that an appointment will be missed or rescheduled.

By signing below, you acknowledge that you have read, understand, and agree to the terms and fee listed above.

_____ _____ _____

Patient Name (Please Print) Patient Signature Date

_____ _____

Witness Signature Date