



# Martha B. Boone, MD LLC

Board Certified Urologist

## Patient Benefits

Patient: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

We have contacted your insurance company. The following is a description of your benefits as of \_\_\_\_\_. The patient is financially responsible for all services received.

Deductible: \_\_\_\_\_ Amount Met: \_\_\_\_\_

Amount Remaining: \_\_\_\_\_

Insurance Pays: \_\_\_\_\_ % of usual and customary charges\*\*.

Patient is responsible for: \$ \_\_\_\_\_ co pay or \_\_\_\_\_ %

Surgical (in office): \_\_\_\_\_

51741: \_\_\_\_\_

Labs: \_\_\_\_\_

Diagnostic Testing: \_\_\_\_\_

CT/MRI: \_\_\_\_\_

OV: \_\_\_\_\_

Please let us know if you do not understand your benefits as listed above. If you are unable to pay your patient portion at the time of service, your appointment will be rescheduled.

*\*\*\*There may be a difference between an insurance company's usual and customary charges and our fee schedule. The patient would be responsible for any difference not paid by insurance. Please supply any documentation that your insurance company requests.\*\*\**

Kindly sign and date this form to indicate that you understand and agree to your benefits.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_