

**ATLANTIC UROLOGY CLINICS**

**ADULT & PEDIATRIC**

Andrew Grudzinski MD  
Glenn Gangi MD

**COASTAL UROLOGY**

James Fogarty DO  
Timothy Quillen MD  
Joseph Wood MD

**GRAND STRAND UROLOGY**

William Bogache MD  
Kenneth Krzyzaniak MD  
Neal Shore MD  
Richard Young MD  
Brian Roberts MD

**WACCAMAW UROLOGY**

Thomas Cerasaro MD  
Walter Frank MD

Atlantic Urology Physicians and staff are dedicated to providing the highest quality healthcare in a professional and timely manner. In order to provide this level of care it is important that our patients are informed of our office policies regarding appointments and assignment of benefits.

**APPOINTMENT POLICY**

- Patients should make financial arrangements prior to the appointment to pay co-pays, deductibles and any out of pocket expenses.
- Payment is due prior to services being rendered for deductible, co-pay and out of pocket expenses.
- Patients should arrive at least \_\_\_ minutes prior to their scheduled appointment.
- Cancellations should be made a minimum of the day prior to the scheduled appointment to avoid a \$30.00 cancellation fee. \_\_\_\_\_ **Initials**
- Patients who do not show up for their scheduled physician appointments will be charged a \$30.00 no show fee. This fee will be collected at the next appointment prior to services being rendered. \_\_\_\_\_ **Initials**
- Our physicians are on call at the local emergency rooms. Your Physician may be delayed for a medical emergency. The office staff will give the patient the option to reschedule their appointment or wait for the Physician to return to the office.
- Minors must be accompanied by a parent or legal guardian.

Compliance with these policies will help assure that all patients are seen in a timely fashion.

**ASSIGNMENT OF BENEFITS**

- I hereby authorize payment of benefits be made directly to Atlantic Urology Clinics. I understand that some services may not be covered by my insurance. Therefore, I will be responsible for payment of any non-covered services as well as any balance not covered by my insurance. \_\_\_\_\_ **Initials**
- I further understand that if my account is turned over to a collection agency a 30% fee will be charged to my account. \_\_\_\_\_ **Initials**

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I have read and agree to the above policies. I authorize the release of any medical or other information necessary to process insurance claims.

Patient/Guardian Signature: \_\_\_\_\_

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

AUC Representative Signature: \_\_\_\_\_