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Monterey Bay Urology Associates

Adult and Pediatric Urology

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Financial Responsibility Agreement

Insured

I, _____ (print name) acknowledge that I am responsible for the payment of any and all services provided to me by Monterey Bay Urology Associates. I agree to pay the co-payment amount, as determined by my insurance company, at the time of my appointment. I understand that Monterey Bay Urology Associates will bill my insurance company as a courtesy to me and that I will be billed for any amount that is not covered by my insurance. I agree to pay the Patient Balance Due upon receipt of the Statement from Monterey Bay Urology Associates.

Signature _____ Date: _____

Social Security # _____ Date of Birth: _____

Witness: _____ Date: _____