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

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.)** 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 and will bill your insurance, but you have a higher deductible and/or out-of-pocket expense. You may not have any out of network benefits and the total bill would then be your responsibility. For questions about your coverage and/or benefits, **please call your insurance** for information about out of network benefits.

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

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 and report with you, unless they were done at St Jude.

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.

Test Results Policy

It is our office policy to request that the patient call our office for these results. **Do not assume that they are normal if** you have not heard from us within 1 week, call our office for your results. **You** should take responsibility to make sure you know they have been reviewed. We will call you regarding abnormal results, but sometimes results are not sent to us but to another physician or office.

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