Patient Financial Responsibilities Form

Effective Date: 01/01/2026

Patient Name: _____

Date of Birth: _____

Account Number (if applicable): _____

Purpose:

To help you understand your financial obligations regarding the care and services provided by Linke Robotics LLC ; DBA Linke Urology and Robotics.

1. Insurance Coverage

We will bill your primary and secondary insurance carriers as a courtesy.

You are responsible for knowing the terms of your insurance policy, including:

- - Co-pays
- - Deductibles
- - Coinsurance
- - Referral or prior authorization requirements

Providing accurate insurance information is your responsibility.

2. Co-Payments & Deductibles

Co-payments are due at the time of service.

If your insurance has a deductible, you are responsible for charges applied toward it which may be collected on the day of service

We may collect a deposit toward services not fully covered by insurance.

3. Self-Pay Patients

If you do not have insurance or choose not to use it, you are responsible for full payment at the time of service.

4. Non-Covered Services

Some procedures may not be covered by insurance (e.g., vasectomy, elective circumcision).

You are financially responsible for any non-covered services.

You will be informed of these costs in advance.

YOU MAY RETAIN THE RIGHT TO WAIVE LINKE ROBOTICS LLC FROM BILLING YOUR INSURANCE IF YOU PREFER TO CASH-PAY FOR SERVICES

5. Out-of-Network Services

If we are not in-network with your plan, you may incur higher out-of-pocket costs.

It is your responsibility to verify our participation with your insurance provider.

6. Billing & Payment Terms

We collect patient financial responsibility on the day of service when permissible, including copays and estimated deductibles or coinsurance.

Co-Pays will be collected during patient registration

Estimated deductible and coinsurance will be collected after the visit utilizing patient insurance estimator of real-time benefits. All insurance claims are submitted promptly. Final patient responsibility is determined after insurance adjudication. What is collected on day of service is simply an estimate, and the final declaration will be made by your insurance when sending the explanation of benefits

For operative/procedural services, the physician fee will be due 7 days prior to the day of service. If this is not paid within this timeframe, Linke Robotics LLC reserves the right to reschedule your service. If there is underpayment to Linke Robotics LLC, it is due to be paid within 30 days of service. If there is overpayment to Linke Robotics LLC, it will be refunded within 30 days.

Procedures performed within the clinic will require a deposit to schedule (e.g. vasectomy, cystoscopic procedures, BPH related procedures, etc)

Accepted forms of payment: cash, check, debit, credit card, HSA/FSA.

7. Returned Checks / Missed Appointments

Returned checks incur a $25 fee.

Missed appointments or cancellations with less than 24 hours' notice may be subject to a $50 fee.

8. Delinquent Accounts

Accounts not paid after reasonable attempts may be referred to a collection agency.

You are responsible for any collection or legal fees incurred.

9. Questions

If you have questions regarding your bill or need assistance, contact our billing department at:

Layla Pajazetovic 260-702-9515

Acknowledgment and Signature

I have read and understand the above financial responsibilities. I agree to be responsible for all charges incurred for services rendered by Linke Robotics LLC ; DBA Linke Urology and Robotics

Patient/Guardian Signature: _____

Date: _____