Patient Out of Pocket ESTIMATE Form

Dear

It is our mission and our service to you that we make your experience with our practice and surgery center as pleasant and transparent as possible. Part of this service is to contact your insurance company(s) to determine your out-of-pocket expenses prior to your visit or procedure so that you may include this information in your decision making process. It is important for you to remember that this is an estimate, and while we will do our best to give you the most accurate number, there are many variables which could change this number prior to your visit or procedure.

Date of Service: _____/_____/_____ Type: ☐Visit ☐Procedure ☐Surgery ☐Other

Date form Completed: _____/_____/_____ Person completing: _____

Specific Service: _____

Additional Services (anesthesia, devices, etc…): _____

Primary Insurance: _____ Secondary: _____

Worksheet		Additional Notes
Balance on Deductible		
Copay		
Allowable - Clinic/Physician		
Allowable - Surgery Center		
% insurance pays after deductible		
Secondary Insurance Calculation		
Charges (lab, anest, etc…)		
Other:		
Estimated Out-Of-Pocket		

Will patient receive bill from anyone other than Washington Urology? _____

If yes, for which services: _____