C FM WU The Center For Men's and Women's Urology

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Patient Name: _____

Please initial each "_____"

_____ **ASSIGNMENT OF BENEFITS & AUTHORIZATION TO RELEASE MEDICAL INFORMATION**

I request that payment of authorized benefits{Medicare, managed HMOs/IPAs and/or insurance companies) be made either to me or on my behalf to The Center for Men's and Women's Urology for any services furnished to me by my provider. I authorized any holder of medical information about me to release it to the following when applicable to determine benefits for related services:

Division of Family Services
Centers for Medicare and Medicaid Services
Insurers and/or agents of these companies
Responsible person(s) listed
Other healthcare providers assisting in my medical care

_____ **CONSENT TO TREATMENT**

I hereby authorize The Center for Men's and Women's Urology and/or any physician or authorized persons employed by them to perform and/or initiate medical evaluation and treatment and authorize and/or order any related services on my behalf.

_____ **FINANCIAL AGREEMENT**

I understand unless other arrangements have been made in advance by either me or my health coverage carrier, payment in full is due at the time of service. Acceptable methods of payment are cash, personal checks, VISA, MasterCard, Discover Card, AMEX or Credit Card.

The Center for Men's and Women's Urology has made prior arrangements with many health plans to accept an assignment of benefits. We will submit a claim to those plans for which we have an agreement and will require you to pay the authorized co-payment, deductible and/or co-insurance at the time of service. If you have insurance coverage with a plan that we do not have a prior agreement, we will prepare and send a claim for you on an unassigned basis. This means our charges for your care and treatment are due from you at the time of service and your insurer will send their reimbursement directly to you.

If you have any questions or concerns regarding your coverage for procedures, screenings services, medications or particular conditions, you are responsible for obtaining this information prior to your appointment from your health plan. You agree to pay in full for all services considered "non-covered" services per your insurance policy if you choose to have the service provided.

If your insurance company does not pay for the services provided, or you do not have insurance, you agree to pay all charges of The Center for Men's and Women's Urology. Each bill is due and payable upon presentation or mailing of a statement to you. Should the account become delinquent, you agree to pay all costs of collection applied by a collection agency, interest and attorney fees. Any suit files may be brought in the county where the services are rendered.

_____ **PHYSICAL FORM COMPLETION**

I understand if I, or a person/entity on my behalf, request The Center For Men's and Women's Urology to complete a disability, home health, or other physical form, the Practice will assess me a $25 fee for simple, and $40 for detailed paperwork. Please allow 48 hours to complete.

_____ **CANCELLATION POLICY**

I understand I will be assessed a $25 fee for Office Visits, $50 fee for in-office procedures and a $100 fee for hospital surgeries by The Center For Men's and Women's Urology, per their Cancellation Policy, if I:

Do not show up for my appointment, or
Do not cancel my appointment with a minimum of 24 hour notice.

_____ **RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT**

I have received a copy of, or viewed online at www.1URO.com, The Center For Men's and Women's Urology Notice of Privacy Practices

I understand and agree to all of the above:

_____ _____

Signature of Patient (For patients 17 years of age or younger, a parent or guardian MUST sign) **Date**

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