SIGNATURE FORM

FINANCIAL RESPONSIBILITY AND RELEASE OF INFORMATION

I understand that I am financially responsible to Urology Specialists, S.C. for charges not covered by my insurance carrier. Payment for services is due at the time of service unless prior arrangements have been made. I also agree that, should I fail to assume financial responsibility and credit action is necessary, I will pay for these costs in addition to the amount of the doctor's charges. I authorize Urology Specialists, S.C. to release to the Social Security Administration or its intermediaries or carriers, or other insurance carrier any medical or other information needed for this or a related insurance claim. A copy of this authorization may be used in place of the original.

_____	_____	_____
Date	Please Print Patient's Name	Signature of Patient or Guardian

EXTENDED PAYMENT REQUEST (ONE TIME AUTHORIZATION)
(Medicare and Medicaid Patients ONLY)

I request that payment of authorized Medicare benefits or other insurance benefits be made on my behalf to Urology Specialists, S.C. for any services furnished me by this provider. This **one time signature** will be maintained on file as verification for all subsequent services which are provided to me by this provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents or other insurance carriers any information needed to determine these benefits or the benefits payable for related services.

_____	_____	_____
Date	Please Print Patient's Name	Signature of Patient or Guardian

MEDIGAP AUTHORIZATION
(Medicare Patients ONLY)

I request that payment of authorized Medigap benefits be made on my behalf to Urology Specialists, S.C. for any services furnished me by this provider. I authorize any holder of medical information about me to

_____ any information needed to determine these benefits or
(Name of Medigap Insurer)
the benefits payable for related services
.

Medicare Number: _____

Secondary Insurance: _____ Policy #: _____

_____	_____	_____
Date	Please Print Patient's Name	Signature of Patient or Guardian

RECEIPT OF PRIVACY PRACTICES

The Notice of Privacy Practice provides detailed information about how Urology Specialists, S.C. may use and disclose my confidential information. **A copy of the Urology Specialists Privacy Practices will be made available at the time of my appointment.**

_____	_____	_____
Date	Please Print Patient's Name	Signature of Patient or Guardian