

UROLOGY ASSOCIATES, P.C.

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TEL: 516 627-6188 • FAX: 516 627-9397
WEBSITE: www.urologyassociatespc.com

Date: _____

Patient Name: _____

Chart #: _____

If we participate with your insurance carrier please note the following:

If your insurance requires a **REFERRAL**, you are responsible for obtaining one from your primary care physician. If your insurance requires you to use a specific lab, please indicate the name of the lab and inform the nurses.

Lab: _____ Patient Initial: _____

FEE POLICY: Patients are responsible for all unpaid fees regardless of insurance coverage. I understand that payment is required at the time services are rendered unless other arrangements have been made in advance. I understand that I am responsible for payment in full for all coinsurance and deductible costs, as well as any Doctor's services which are determined to be non-covered or denied. I understand that if my Secondary Insurance fails to pay within 60 days from date of service, I will receive a notice for these unpaid services and a HCFA (billing) form so that I can submit directly to my Secondary carrier. I authorize my physician to release any medical information necessary to process my bill.

Signature: _____

INSURANCE AUTHORIZATION AND ASSIGNMENT

Name of Policy Holder: _____ HIC Number: _____

I request payment of authorized Medicare/Other Insurance Company benefits to be made to me or on my behalf to Urology Associates for any services furnished me by this party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

I authorize the holder of medical or other information about me to release it to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers of information needed for this or a related Medicare/Other Insurance Company claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 USC 3801-3812 provides penalties for withholding this information.)

Signature: _____