

UROLOGY ASSOCIATES, P.C.

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CONSENT FOR SURGICAL FEES

RE: _____

I am hereby stating that I am aware that I will be responsible for
Dr. _____ fee for the surgery listed below.

Procedure: _____

FEE: _____

Please note this is an estimated fee, as the exact fee is based on the
precise surgical procedure, which cannot be established until after the
surgery is performed.

I realize that this fee will be my total responsibility, as I do not have any
medical insurance coverage.

This signed form plus one-third of the above fee (cash or bank check only)
must be received by our office prior to your admission to the hospital or we
will have no choice but to cancel your surgery. Balance of the fee to be
made in monthly payments.

NAME (print) _____

SIGNATURE _____ Date _____