Wichita Urology **Patient Name** _____

Patient Authorization Form **Acct #** _____

Financial Responsibility- I agree to pay Wichita Urology any and all charges for services rendered. I understand that regardless of any assigned insurance benefits, I am responsible for paying the total charges for all services rendered. Any co-payments, estimated deductibles and coinsurances are due, in full, at the time of services. Unless other arrangements are approved in writing, all remaining balances will be due and payable upon receipt of each billing statement and shall be considered past due by the end of the month.

Payment Options-I shall submit payment to Wichita Urology by cash, check, or credit card. Visa, Mastercard and Discover are accepted. There will be a $25 service charge for all returned checks. Special financing is also offered through Care Credit for those patients who qualify. Several options are available with approval including 6, 12, 18 month deferred interest plans as long as the balance is paid in full within the promotional period. I may also secure bank, credit union, or other third-party financing to pay the entire amount and submit payments directly to the appropriate lending institution.

Authorization for Care- I grant permission for Wichita Urology to render such care and treatment as my physician deems medically necessary. I understand that such care may include medical and surgical treatment, laboratory tests, and diagnostic tests. Other independent providers may also be involved in my treatment. These could include radiologists, pathologists, anesthesiologists, etc. Billing from and payment to these entities will be separate.

Insurance Assignment- I hereby authorize direct payment of surgical/medical benefits to Wichita Urology for services rendered. I understand that I am responsible for charges not covered by my insurance or Third Party Payors. I agree to cooperate, aid and assist Wichita Urology in procuring all possible insurance proceed payments for services rendered. I understand that it is my responsibility to comply with all precertification requirements.

Medicare Assignment of Benefits- I certify that the information given in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Center for Medicare and Medicaid Services or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for the physician services to Wichita Urology and authorize Wichita Urology to submit claims to Medicare for payment. I understand that I am responsible for any health insurance deductible and coinsurance.

Authorization for Release of Information- I hereby authorize Wichita Urology to disclose necessary information from the patient's medical record to the parties listed below when requested for the purposes as stated herein; to any physician for the purpose of providing continuing professional care and to any insurance company or third party payor for the purpose of obtaining payment to Wichita Urology for the services provided. Wichita Urology, its employees, officers and physicians are released from legal responsibilty or liability for the release of the above information to the extent indicated and authorized herein. I understand this release specifically includes any and all blood and related tests including test results reflecting presence of HIV, HBV, and the diseases, all of which I specifically authorize to be so released.

*Parties **other than patient and patient's doctor(s)** that are authorized to receive medical information:*

_____ Relation to patient_____
(please print)

_____ Relation to patient_____
(please print)

_____ Relation to patient_____
(please print)

_____ Relation to patient_____
(please print)

Patient Privacy Act- I acknowledge that the Notice of Privacy Practices of Wichita Urology has been offered to me and is available upon request at any time.

WITH THIS SIGNATURE BELOW I ACKNOWLEDGE TO ALL THE INFORMATION ABOVE.

_____ _____ _____
Signature of Patient or Representative Relationship Date

Wichita Urology complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.