Patient Authorization Form

Patient Information

Patient Name	Social Security	Date of Birth

Authorization Information

I understand that my home, answering machine, voice mail messaging, and/or office will be called in the normal course of business:

- to remind me of appointments
- to leave messages that the physician or nurse need to talk to me
- to initiate other necessary contacts
  These contacts have potential to break confidentiality: I agree to these contacts.

Patient's name, or custodial parent/legal guardian if patient is a minor:

☐ **I have read, understand, and approve all the information provided to me above.**

Note: If you do not agree to the above terms, you may make arrangements to have all contacts regarding medical issues conducted in person in our office.

I understand the TEST RESULTS will be reported only to me unless otherwise directed in writing.

Patient's name, or custodial parent/legal guardian if patient is a minor:

☐ **I have read, understand, and approve all the information provided to me above.**

1. I authorize the physicians of Urology Center of the South, P.C. to treat me, or my minor child who is named above, medically.

2. I request that payment of authorized Medicare/Medicaid and/or other health insurance benefits be made on my behalf of the physicians members of the Urology Center of the South, P.C. for any services furnished me by that provider. I authorize any holder of medical information about me to be released to the Health Care Financing Administration or my designated insurance company any information needed to determine these benefits or the

benefits payable for related services.

3. I agree that for and in consideration of acceptance by Urology Center of the South, P.C. for services rendered to me, hereby obligates me, and I assume financial responsibility and agree to pay upon demand to Urology Center of the South, P.C. all charges for such services and incidentals incurred to me, unless otherwise specified under my contracted PPO/HMO agreement. If I am covered under Medicare Part B Program, I agree to pay my annual deductible and a 20% co-payment. Should the account be referred to an attorney for collection, I shall pay reasonable attorney fees and collection expenses. I understand that all bills are payable upon presentation and that I, not the insurance company, am responsible for the payment of all services.

4. I hereby authorize Urology Center of the South, P.C. to release all sociological and medical information officially acquired in the course of examination and treatment for the purpose of filing for insurance benefits and other financial coverage.

5. I also understand that if I am enrolled in a managed care insurance plan, I am responsible at each time of service, for informing Urology Center of the South, P.C. of any special requirements of my insurance plan, including but not limited to, how often services may be rendered or where those services may be performed. If I do not inform Urology Center of the South, P.C. and services are performed which are not covered, such as lab work, procedures, tests, or hospitalizations, Urology Center of the South, P.C. or the selected medical facility will bill me directly for those charges.

Patient's name, or custodial parent/legal guardian if patient is a minor:

☐ **I have read, understand, and approve all the information provided to me above.**

SUBMIT AUTHORIZATION INFORMATION

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