

Chart # \_\_\_\_\_

Date \_\_\_\_\_

Dr. # \_\_\_\_\_



**Assignment of Insurance Benefits**

I authorize direct payment to Urology Specialists of the Carolinas, PLLC and/or my attending physicians of all medical Insurance benefits to which I am entitled. I understand that I am financially responsible to Urology Specialists of the Carolinas, PLLC, my physicians, and other entities named in this assignment for charges covered by this assignment.

**Authorization for Release of Medical Information**

I authorize Urology Specialists of the Carolinas, PLLC and/or my attending physicians to furnish any medical information relating to my hospitalization or treatment to my insurance company, government or charitable agencies and their agents, my employer and professional review organizations with whom I may have insurance coverage or who may be assisting in payment of my medical care. I also authorize Urology Specialists of the Carolinas, PLLC and/or my attending physicians to release any medical information to any licensed physician or medical facility to which I may be referred or transferred for further medical care. This authorization will expire one (1) year from the date shown below, and I understand that I or my legal representative may revoke this authorization at any time, except to the extent that action has already been taken or in the event of my death, the release of medical information is necessary to verify any charges incurred by me. I understand that the information to be released/exchanged may include information regarding drug abuse, alcohol abuse, sickle cell anemia, and /or AIDS (acquired immune deficiency syndrome), AIDS-related complex (ARC) and HIV antibody testing.

**Payment Guaranty**

I (patient or responsible party) agree to pay all charges for services rendered by Urology Specialists of the Carolinas, PLLC and/or my attending physicians during my treatment. If assistance is needed, arrangements may be made with the Patient Account Representative for a reasonable payment plan. If I fail to pay all charges and Urology Specialists of the Carolinas, PLLC and/or attending physicians use an attorney to collect unpaid charges, I agree to pay the reasonable cost of the attorney's services in addition to the unpaid charges.

\_\_\_\_\_  
Patient / and or Responsible Party

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

**Assignment of Insurance / Release of Medical Information**