

LIFETIME AUTHORIZATIONS

* * * All patients to read and sign * * *

1. I authorize treatment for the patient listed on the reverse side of this sheet.
2. I consent to having copies of the records of my visits to this office sent to my referring physician and any physician I am referred to by the Doctors, and to my Primary Care Doctor (current and future).
3. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER PAID BY MY INSURANCE OR NOT AND THAT ANY COLLECTION COSTS INCURRED BY THE PRACTICE SUCH AS COURT COSTS, FEES, ARE MY RESPONSIBILITY.
4. I hereby authorize release of information necessary to file a claim with my insurance company and ASSIGN BENEFITS OTHERWISE PAYABLE TO ME TO – OCALA UROLOGY SPECIALISTS, P.A.
5. I certify that all information given on this and the INFORMATION SHEET above is correct to the best of my knowledge.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment

Patient Date Witness Date

SUBSCRIBER (if different for patient) _____

MEDICARE PATIENTS ONLY

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize the release of medical or other information XIX about me to the Social Security Administration and the Health Care Financing Administration or its intermediaries or carriers. A copy of this signature may be used in place of the original, and I request payment of medical insurance benefits to Ocala Urology Specialists, P.A. This authorization remains valid for my lifetime or until otherwise revoked by myself.

Patient Date Witness Date