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<i>Information Release</i> Patient: _____ DOB: _____ (Please fill out information for all insurance companies that apply to you or your dependant)		
If you have...	Please read the following release...	Please sign in agreement with the previous stated terms
Medicare Insurance  ID#: _____  _____	I request that payment of authorized Medicare benefits be paid on my behalf to Urological Care, Inc. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.	Signature: _____  Date: _____
Medicare Supplement Company:  ID#: _____  _____	I request that payment of authorized Medigap benefits be paid on my behalf to Urological Care, Inc. for any services furnished to me by the physicians of Urological Care, Inc. I authorize any holder of medical information about me to release to my insurer any information needed to determine these benefits or the benefits payable for related services.	Signature: _____  Date: _____
Commercial and Managed Care Insurance  ID#: _____  _____	I authorize the physicians of Urological Care, Inc. to furnish information to insurance carriers concerning the illness or medical treatment of my dependent or myself, and I hereby assign to the provider all insurance payments for medical services rendered to myself or my dependent, except for those services for which I have already paid prior to filing of the claim on my behalf. I also acknowledge responsibility for payment of all medical fees regardless of any insurance I may have to assist me in the responsibility. If for any reason the account should become delinquent, I agree to pay for all collection and legal fees. I agree that a photocopy of this form may be used in place of the original.	Signature: _____  Date: _____
Self-Pay Patients	I acknowledge responsibility for payment of all medical fees due to the lack of insurance. I agree that a photocopy of this may be used in place of the original.	Signature: _____  Date: _____

If it becomes necessary to employ a collection agency, service or attorney to enforce payment, you agree to pay for the costs and the fees charged for such services. These include, but are not limited to, attorney's fees, and the cost of court proceedings through judgment and execution of judgment and appeal.

Responsible Party's Signature: \_\_\_\_\_ Date: \_\_\_\_\_