

**COLLIN COUNTY UROLOGY**  
**INFORMATION AND ASSIGNMENT OF BENEFITS**

**I understand that the patient co-payment/deductible responsibilities are to be paid at the time of service and that all charges are my responsibility whether or not they are paid by insurance.** If I have Medicare or belong to an HMO, POS, MC, or PPO the terms of the doctor's contract with the network will govern payment policies.

I hereby authorize the physicians of Collin County Urology and the staff to apply for benefits on my behalf for covered services rendered by him/her, or by his/her order. I request that my insurance company mail payment directly to Collin County Urology (or to the party who accepts assignment).

I hereby authorize Collin County Urology as my representative if my insurance is an ERISA plan.

**I certify that the information I have given on my insurance coverage is correct and accurate.**

Date: \_\_\_\_\_ Signature: \_\_\_\_\_  
(Patient or Guardian)

I hereby permit Collin County Urology to release and furnish all medical and financial data related to my care that may be necessary now or in the future for purposes of treatment, payment or healthcare operations to assist with, aid in, or facilitate the collection of data for purposes of utilization review, quality assurance, or medical outcomes evaluation purposes. Such information may be released to insurance companies, HMO's, PPO's, Managed care organizations, IPA's, Medicare and/or other governmental or third party payors, or any organizations contracting with any of the above entities to perform such functions.

I understand that I have the right to review the Notice of Privacy Practices of Collin County Urology. I have the right to revoke this consent in writing, except to the extent that this office has previously taken action in reliance on this consent. This request can be denied if required for treatment, payment collection or health care operations.

**I permit a copy of this authorization to be used in place of the original.**

Date: \_\_\_\_\_ Signature: \_\_\_\_\_  
(Patient or Guardian)