FINANCIAL RESPONSIBILITY AND RELEASE OF INFORMATION

I understand that I am financially responsible to Atlantic Urology Medical Group for charges not covered by my insurance carrier. Payment for services is due at the time of service unless prior arrangements have been made. I also agree that, should I fail to assume financial responsibility and credit action is necessary, I will pay for these costs in addition to the amount of the doctor's charges. I authorize Atlantic Urology Medical Group to release to the Social Security Administration or its intermediaries or carriers, or other insurance carrier any medical or other information needed for this or a related insurance claim. A copy of this authorization may be used in place of the original.

_____ _____

Signature of patient or legally authorized individual Date

EXTENDED PAYMENT REQUEST (One Time Authorization)
(Medicare and Medicaid Patients Only)

I request that payment of authorized Medicare benefits and other insurance benefits be made on my behalf to Atlantic Urology Medical Group for any services furnished to me by that provider. This one time signature will be maintained on file as verification for all subsequent services which are provided to you by this provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents or other insurance carriers any information needed to determine these benefits or the benefits for related services.

_____ _____

Signature of patient or legally authorized individual Date

MEDIGAP AUTHORIZATION
(Medicare Patients Only)

I request that payment of authorized Medigap benefits be made on my behalf to Atlantic Urology Medical Group for any services furnished to me by that provider. I authorize any holder of medical information about me to release to _____ and information needed to determine these benefits or the

(Name of Medigap Insurer)

benefits payable for related services.

Medicare Number: _____

Secondary Insurance: _____ Policy:_____

_____ _____

Signature of patient or legally authorized individual Date