

**JOHNSON CITY UROLOGICAL CLINIC**

**STATEMENT OF FINANCIAL RESPONSIBILITY**

PRINT PATIENT NAME \_\_\_\_\_

1. **PRIVATE INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION:** I hereby authorize and direct payment of my medical benefits to Johnson City Urological Clinic, for any services furnished to me by the physicians. I authorize the physician to release any information, including diagnosis and the records of any treatment or examination rendered to my child or me during the period of such medical services to third party payers and/or health practitioners. In the event that my health plan determines a service to be "not covered", I will be responsible for the complete charge. I agree to be responsible for payment of all unpaid services rendered on my behalf or my dependents, including any fees for collection services needed.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Patient (or Responsible Party)

2. **PAYMENT**  
I hereby assume responsibility to pay the cost of all services provided by Johnson City Urological Clinic and its physicians to the patient.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Patient (or Responsibility Party)

3. **AUTHORIZATION OF PAYMENTS**  
I understand that Johnson City Urological Clinic will assist me in submitting my claim to my insurance carrier. I hereby authorize payment directly to Johnson City Urological Clinic and its physician(s) of medical benefits, otherwise payable to me, for the services provided. I understand that I am financially responsible for my health insurance deductibles, coinsurance and non-covered services.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Patient (or Responsible Party)

4. **LABORATORY BILLS**  
I understand the outside reference laboratory will bill me directly for all laboratory tests performed by the company. I understand that fee schedule (cost) for laboratory tests performed by an applicable laboratory shall be available to the patient upon request.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Patient (or Responsible Party)

5. **MEDICARE LIFETIME SIGNATURE ON FILE**  
I request that payment of authorized Medicare benefits be made either to me or on my behalf to Johnson City Urological Clinic for any services furnished me by the physicians. I authorize any holder of medical information about me to release to the Center of Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Patient (or Responsible Party)

(Cont)

**6. MEDIGAP AUTHORIZATION FOR ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION.**

I request that payment of authorized Medigap benefits be made to either me on my behalf to Johnson City Urological Clinic for any services furnished to me by the provider of service. I authorized any holder of medical information about me to release to the Medigap insurer any information needed to determine these benefits payable for related services.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Patient (or Responsible Party)

\_\_\_\_\_  
Health Insurance Claim Number

\_\_\_\_\_  
Medigap Policy Number