ASSOCIATES IN GENITOURINARY SURGERY, P.C.
Adult and Pediatric Urology

■ Howard R. Usitalo, M.D. ■ David Lutchka, P.A. C. ■

PATIENT AUTHORIZATION FORM

HIPPA RECEIPT: ____
I acknowledge that I have read, understand and received a copy of the ***Notice of Privacy Practices for Associates in Urology.***

MEDICATION AUTHORIZATION: ____
I authorize Associates in Genitourinary Surgery to communicate and share my personal information with other medical facilities in order to provide medications/prescriptions as necessary.

PROCEDURE CONSENT: ____
I authorize Associates In Urology to perform procedures in the office and/or release any/all patient identifiable information in order to conduct insurance research for services which may or may not include:

Botox, Cystoscopy, Ultrasound, Biopsy, Vasectomy

BILLING AGREEMENT

As a courtesy, we will submit all fees to your insurance company, both primary and secondary. Charges sent to you after insurance payments or self pay visits are due within 30 days. We understand that patients may experience financial difficulty due to personal circumstances. Please contact the office to discuss the problem and setup a payment plan agreement.

If your insurance company requires a referral, it is your responsibility to obtain this document for each visit to our office.

□ Self pay. No insurance _____ (initial)

□ I understand that I have nonparticipating insurance _____ (initial) . (If we do not participate with your insurance company we will send you a statement after payment from them with your personal balance. Please contact your carrier to determine “out of network” reimbursement.)

I HAVE READ AND UNDERSTAND THE ABOVE AUTHORIZATIONS, POLICIES AND FINANCIAL RESPONSIBILITY:

DATE: _____ Printed Patient Name: _____

Patient Signature: _____
OR Parent/Guardian Signature (for patient under 18):

Witness: _____