NEW JERSEY UROLOGIC INSTITUTE

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Patient Name: _____ N.J.U.I. ID# _____

MEDICARE LIFETIME SIGNATURE ON FILE:

I authorize payment of Medicare benefits to New Jersey Urologic Institute, P.A. for services rendered to me. I understand that I am financially responsible for balances not covered by insurance. I authorize release of medical information about me to the Centers for Medicare and Medicaid Services and to my insurance company to determine benefits.

PLEASE NOTE: URINE CULTURES CYTOLOGIES & PATHOLOGY STUDIES MAY BE SUBJECT TO ADDITIONAL TESTING BY OUTSIDE LABORATORIES. YOUR INSURANCE COMPANY WILL BE BILLED SEPERATELY BY THESE OUTSIDE LABS.

X_____
Signed Date

ALL OTHER INSURANCES:

I authorize payment of any insurance benefits to New Jersey Urologic Institute, P.A. for services rendered to me or my dependent. I understand that New Jersey Urologic Institute will submit claims to my insurance company and that I am responsible for all co-pays, deductibles and charges for services not covered by my insurance company. I authorize the release to my insurance company of medical information in order to evaluate and pay medical claims.

PLEASE NOTE: URINE CULTURES CYTOLOGIES & PATHOLOGY STUDIES MAY BE SUBJECT TO ADDITIONAL TESTING BY OUTSIDE LABORATORIES. YOUR INSURANCE COMPANY WILL BE BILLED SEPERATELY BY THESE OUTSIDE LABS.

X_____
Signed Date