UGNJ

UROLOGY GROUP OF NEW JERSEY, LLC

ASSIGNMENT OF BENEFITS & AUTHORIZATION TO RELEASE INFORMATION

I authorize payments and/or insurance benefits to UGNJ for medical services and/or surgical procedures that are payable to me under any government or private plan of health benefits, including Medicare payments, Medigap payments, and any other payments from private or self-insured plans. I certify that the information that I gave to UGNJ is correct. I assign and transfer to UGNJ the right to act in my place to bill and collect for all payments that are payable to me under any government or private plan of health benefits. I understand that I am responsible for any deductible, coinsurance, copayment and non-covered services.

I understand UGNJ is allowed to use and disclose my health information for treatment or payment and I understand this use is allowed by law. I hereby authorize UGNJ to release any such medical information as necessary.

FINANCIAL AGREEMENT

I understand that if UGNJ does not participate with my insurance payer, and I still wish to be seen, I can be seen as a "Self-Pay" patient. I understand that I will be required to pay the total cost of the visit in advance. UGNJ may courtesy file a claim to my non-participating insurance on my behalf or a claim form will be provided to me by the Billing Office.

NON-COVERED SERVICES

I understand that UGNJ's contracts with health care insurance carriers and other payers relate only to items and services which are "covered" by the health benefits carriers and other payers. Accordingly, I accept full financial responsibility for all items or services, which are determined by the health benefits carrier or other payers not to be covered. Examples of services not eligible for payment include, but are not limited to, services which are determined as not medically necessary, non-covered, experimental or not otherwise specified as being covered in the patient's contract or in a benefit summary furnished to the patient beneficiary.

APPOINTMENT CANCELLATION

I understand that if I need to cancel or reschedule my appointment, I need to do so a minimum of twenty-four (24) hours in advance of my scheduled appointment time. Failure to comply may result in an appointment cancellation fee.

NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided with a copy of UGNJ's Notice of Privacy Practices, which describes how medical information about me may be used and disclosed and how I can have access to this information.

I have read, understand, and agree to the provisions outlined in the paragraphs above.

SIGNATURE

Print Name: ____

Patient Signature: ____

Date: ____

Practice Partner Patient Id Number: ____