Urology Partners of Western Kentucky

James Fellows MD

Patient Name: _____ **Date:** _____

SIGNATURE FORM

FINANCIAL RESPONSIBILITY, RELEASE OF INFORMATION, AND NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that I am financially responsible to Dr. James Fellows for charges not covered by my insurance carrier. Payment for services is due at time of service unless prior arrangements have been made. I also agree that, should I fail to assume this 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 Dr. Fellows to release to the Social Security Administration or its intermediaries or carries, 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.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting the office.

Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information.

By my signature below I acknowledge that I have read and understand the Urology Partners of Western Kentucky Billing Policies as well as my financial responsibility, and I acknowledge receipt of the Notice of Privacy Practices.

Signature of Patient or Guardian: X_____ **Date:** X_____

AUTHORIZATION FOR PERSONS TO WHOM INFORMATION MAY BE DISCLOSED:

_____ _____

Print name of person/organization

_____

Relationship to Patient

_____

Print name of person/organization

_____

Relationship to Patient

Please continue only if you have Medicare or Medicaid

EXTENDED PAYMENT REQUEST (ONE TIME AUTHORIZATION)

I request that payment of authorized Medicare benefits or other insurance benefits (including Medigap benefits) be made on my behalf to Urology Partners of Western Kentucky for any services furnished 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 payable for related services. I authorize any holder of medical information about me to release to the Medigap Insurer (if applicable) any information needed to determine these benefits or the benefits payable for related services.

Signature of Patient or Guardian: X _____ **Date:** X _____