ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct payment of surgical/medical benefits to Dr. J. Francois Eid/Advanced Urological Care, for services rendered by him in person or under his supervision. I understand that I am financially responsible for any balance not covered by my insurance (this includes deductible, co-insurance, and non-covered services) .

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Dr. J. Francois Eid /Advanced Urological Care, to release any medical or incidental information that maybe necessary for either medical care or in processing applications for financial benefit.

MEDICARE

I certify that the information given by me in applying for payment is correct.
I authorize release of all records on request. I request that payment of authorized benefits be made on my behalf.

A photocopy of these assignments shall be valid as the original.

NOTICE OF PRIVACY PRACTICES

I have received or I have been provided the opportunity to receive a copy of the "NOTICE OF PRIVACY PRACTICES" that explains when, where, and why my confidential health information may be used or shared. I acknowledge that J. Francois Eid, M.D./ Advanced Urological Care and the Staff may use and share my confidential health information with others in order to treat me, in order to arrange for payment of my bill and for issues that concern J. Francois Eid, M.D./Advanced Urological Care's operations and responsibilities.

PATIENT(PLEASE PRINT)__________________________DATE________
PARENT/GUARDIAN____________________
SIGNATURE________________________________