Urology Partners Assignments of Benefits, Right to Payment Authorization & Release of Information Form

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A Division of 21st Century Oncology, LLC

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Assignment of Benefits/Right to Payment Authorization

I, the undersigned, assign the provider/entity reference above ("Provider"), my rights & benefits in any medical insurance plan, health benefit plan or other source of payment for healthcare services (each a "Plan") in connection with medical services provided by Provider, it's employees & agents. I understand that this document is a direct assignment of my rights & benefits under my Plan.

I authorize my insurance company to pay Provider directly for the professional or medical expense benefits payable to me. If my current policy prohibits direct payment to Provider, I instruct my insurance company to make out the check to me & mail it directly to the address of lockbox referenced above for the professional and/or medical expense benefits payable to me under my Plan as payment towards the total charges for the services rendered. In addition I agree & understand that any funds I receive by my insurance company due for services rendered by Provider are owed to Provider & I agree to remit those funds directly to Provider.

Release of Information

This notice describes how medical information about you may be used and disclosed & how you can get access to this information. Please review & answer the following carefully.

Does Urology Partners, a division of 21st Century Oncology, have your permission to:

1. Leave a detailed message on your voicemail? ☐ Y ☐ N
   a. If NO, please let us know how you wish to be contacted by our office? ______________________________
2. Communicate with you via email? ☐ Y ☐ N
   a. If YES, please provide email address ______________________________
3. Release information to anyone other than you? ☐ Y ☐ N
   a. If YES, please list each person below

Name: ______________________________ Relationship ____________________ Phone (____)_____-_______

Name: ______________________________ Relationship ____________________ Phone (____)_____-_______

Name: ______________________________ Relationship ____________________ Phone (____)_____-_______

4. Request your feedback via telephone or email survey? ☐ Y ☐ N
5. Provide individual access to select medical records and/or communicate with you via Patient Portal? ☐ Y ☐ N

WE WILL NOT RELEASE INFORMATION TO ANYONE NOT LISTED ABOVE

This is also to inform you that Protective Health Information (PHI) may be used & disclosed by the covered entity, which includes Physician Offices, Insurance Companies, Home Health Agencies & entities necessary to carry out your treatment, payment or health care operations. This allows us to provide/obtain information to covered entities for continued treatment. You have the right to request restrictions on the uses & disclosures of PHI for treatment, payment & healthcare operations purposes. The covered entity is not required to comply with the individuals request, but if they covered entity does not agree to this request, the restriction is binding on the covered entity. You have the right to revoke this consent in writing, except to the extent that the covered entity has taken action in the reliance on the consent. The terms of the consent are subject to change if a new HIPPA (Health Insurance Portability & Accountability Act), rules are implemented.

I authorize Provider and/or its agents to release any medical or other information about me in its possession to my Plan, the Social Security Administration, any state administrative agency, or their intermediaries or fiscal agents required or requested in connection with any claim for services rendered to me by Provider.

By signing this document I verify that I have read & understand the above information as described above & that I am giving Urology Partners, PA staff consent to release my personal information as described above.

A photocopy of this Assignment/Authorization shall be considered as effective & valid as the original.

______________________________	____________	______________________________	____________
Signature of Patient/Person Legally Responsible	Date	Print Name of Patient/Person Legally Responsible	Date

______________________________ ____________

Name of Patient and Relationship to Patient *(if signed by Person Legally Responsible)* — DOB of Patient