

PRIMARY INSURANCE

Insured's Name: _____
Address: _____
City: _____
State & Zip: _____
Phone: _____ Birthdate: _____
Insurance Co.: _____
Social Security/Medicare#: _____
Group or Policy #: _____
Insurance Co. address if other than Medicare:

Relationship to Patient: _____

SECONDARY INSURANCE

Insured's Name: _____
Address: _____
City: _____
State & Zip: _____
Phone: _____ Birthdate: _____
Insurance Co.: _____
Social Security/Medicare#: _____
Group or Policy #: _____
Insurance Co. address if other than Medicare:

Relationship to Patient: _____

IF YOUR INSURANCE COMPANY REQUIRES YOU TO USE A CERTAIN HOSPITAL, PLEASE GIVE THE NAME BELOW, IF THERE IS NO SPECIFIC HOSPITAL WRITE NONE.

**AUTHORIZATION TO RELEASE INFORMATION
ASSIGNMENT OF INSURANCE BENEFITS:**

I hereby authorize release of information necessary to file a claim with my insurance company and assign to Kulb, Chalian, and Leak Urology, Ltd all money to which I am entitled for medical or surgical expense relative to the service reported herein, but not to exceed my indebtedness to Kulb, Chalian, and Leak Urology, Ltd. It is understood that any money received, over and above my indebtedness, will be refunded to me when my bill is paid in full.

I understand I am financially responsible for charges not covered by my insurance. In the event unpaid charges are referred to an attorney for collection or a collection agency for collection, I understand I will pay all attorney fees, court costs and/or collection fees of 33 1/3% in the enforcement of the unpaid charges.

**A PHOTOSTATIC COPY OF THIS AUTHORIZATION SHALL BE
CONSIDERED AS VALID AS THE ORIGINAL.**

DATE: ____/____/____

SIGNATURE _____
PATIENT PARENT GUARDIAN OTHER _____