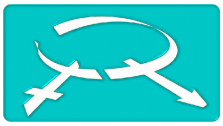

Cadillac Urology Practice
Dr. Brian Drabik, DO, FACOS, PC
Patricia M. Gable, FNP

Release of Information & Assignment of Benefits

I hereby give permission to Cadillac Urology to release information concerning my medical care, consultation, and treatment to my medical insurance provider. I understand that copies of my consultation and other pertinent medical information may be sent to my referring physician, and other professionals involved in my care. I authorize release of information also, in so far as is necessary to complete disability requests, and work & school release requests if and when these become necessary in the course of urological treatment.I expressly agree and acknowledge that my signature below authorizes Cadillac Urology to submit claims for benefits, for services rendered, without obtaining my signature on each and every claim to be submitted. I AGREE TO IMMEDIATELY ENDORSE AND DELIVER TO CADILLAC UROLOGY ANY CHECKS RECEIVED BY ME FROM INSURANCE COMPANIES AS A RESULT OF HIS SERVICES.
I agree to pay for any services that are not covered by my insurance company, and will assume financial responsibility for any insurance claims submitted on my behalf, which are not paid within 60 days.

Medicare
I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. Brian Drabik DO PC and/or to the individual Attending Physician, for any services furnished to me by the Physician. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Servies and its agents any information needed to determine these benefits or the benefits payable for related services. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to myself or the party who accepts assignment.

Medigap (Medicare Secondary Insurance)
I request that payment of authorized Medigap benefits be made either to me or on my behalf to Dr. Brian Drabik, DO PC for any services furnished to me by that physician. I authorize any holder of Medicare information about me to release to my Medigap Coverage any information needed to determine these benefits payable for related services.

RX HISTORY RELEASE
The medication history information would include medications prescribed by your health care provider as well as other health care providers involved in your care and may include sensitive information including, but not limited to, medications related to mental health conditions,venereal diseases/sexually transmitted diseases, abortion(s), rape/sexual assault, substance (drug and alcohol) abuse, genetic diseases, and HIV/AIDS. As part of this Consent Form, you specifically consent to the release of this and other sensitive health information. By signing this consent form you are agreeing that your provider at may request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

Use of Photograph
The undersigned agrees that any patient photographs taken in connection with medical treatment will be considered a part of the patient's medical record and may be used by the patient's health care provider solely for purposes of patient identification.

Payment Policy
All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance cards to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

All co-payments and deductibles must be paid at the time of service.

Patients may be requested to make full payment of unpaid balances when an insurance payment is not received after 60 days of the billing date.

Prior to providing services, payments may be required or payment arrangements must be approved by the billing department.

Accounts that cannot be collected after 90 days may be referred to an outside collection agency or attorney for further collection action.

Patients with unpaid delinquent accounts, accounts that have been written off, or sent to a collection agency may be denied treatment if not medically required.

All returned check fees will be your responsibility and will be applied to your account not to exceed $35.00.

I understand all of the terms defined above; I consent to receiving treatment under the stated terms and I agree to honor all of my financial obligations to Cadillac Urology Practice. My signature below constitutes my Financial agreement and Lifetime Signature Authorization.

The undersigned certifies that each has read and understands the above terms and conditions.

_____
Patient Name (Please Print)

_____
Patient Signature **Date**

_____
Patient's Agent Representative and Guarantor Signature **Date**

Cadillac Urology Practice
1011 Sunnyside Drive Cadillac, MI 49601 779-2565
www.cadillacurology.com

PATIENT INFORMATION

LAST NAME _____**DATE OF BIRTH**_____

FIRST NAME _____**MIDDLE INITIAL**_____

STREET ADDRESS AND PO BOX _____

CITY _____**STATE**_____**ZIP**_____

HOME PHONE # _____CELL PHONE # _____

May we leave a message Y____ N___ Message type: Text _____ Voice_____Both_____

Email Address_____

Participate in Web Portal Yes _____ No _____

EMERGENCY CONTACT _____EMERGENCY PHONE#_____

PATIENT'S SOCIAL SECURITY # _____**SEX**_____

MARITAL AND/OR STATUS _____SINGLE _____MARRIED ___ WIDOWED

RACE ___ HISPANIC/ LATINO ___ ASIAN ___ BLACK / AFRICAN AMERICAN

___ NATIVE HAWAIIAN/OTHER PACIFIC ISLANDER ___ WHITE ___ Refused to report

ETHNICITY ___ HISPANIC OR LATINO ___ NOT HISPANIC OR LATINO ___ Refused to report

PREFERRED LANGUAGE_____

We will scan in your insurance card, please fill in:

Primary Insurance Company_____**Secondary Insurance**_____

Contract/subscriber ID_____ _____

SUBSCRIBER NAME_____**DOB**_____

PREFERRED PHARMACY_____

EMPLOYER (PATIENT) _____

SPOUSE'S NAME _____ DOB _____

PRIMARY CARE PHYSICIAN (CITY & STATE) _____

IF PATIENT IS A MINOR PLEASE FILL OUT

FATHER _____DOB _____

MOTHER _____ DOB _____

FATHER'S ADDRESS (IF DIFFERENT) _____

MOTHER'S ADDRESS (IF DIFFERENT) _____

Family members or persons we may release information to:

_____

SIGNATURE _____**DATE**_____

GUARDIAN OR P.O.A._____

Offfice use only: scan messenger insurance web enabled pharmacy stats