Michael H. Phillips, MD, F.A.C.S.
Jason D. Engel, MD, F.A.C.S.
Paul R. Shin, MD, F.A.C.S.
Harold A. Frazier II, MD, F.A.C.S.
Irwin Shuman, MD, F.A.C.S.

Adult Urology
Male Infertility
Urinary Stone Disease
Urologic Oncology
Impotence
Urinary Infection
Urologic Laparoscopy
DaVinci Robotic Surgery
Reconstructive Urology

Patient Acknowledgement of Benefits and Billing Information

Pre-authorization for care and the acquisition of Primary Care referrals for office visits are the responsibility of the patient and is not a guarantee of payment or benefits. Whether or not your insurance company pays in full, a portion, or no portion of your medical bills is a matter between you and your insurance carrier. As a courtesy to our patients, it is our policy to submit charges directly to the patient's insurance company, with the understanding that the patient is financially responsible for any medical services not covered by their plan. By signing this form you assume financial responsibility for all non-covered services, and visits for which (if necessary) you did not provide an appropriate referral. Failure to provide us with a valid referral at the time of service rendered constitutes a request for out-of-network services.

I, ____, hereby authorize Urologic Surgeons of Washington and the George Washington University Medical Faculty Associates to apply for benefits on my behalf for medical services rendered. I certify that the information I have reported with regards to my medical insurance coverage is correct and further authorize the release of any necessary information, including medical information, for this or any other claim to my health insurance company. I permit a copy of this authorization to be used in place of the original.

_________________________________ ___________ __________________

Signature Date Insurance Co.