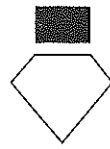


Ira A. Zucker, M.D.*
Brian N. Schwartz, M.D.*
Barry F. Blitz, M.D.*



FLORIDA
UROLOGY
PHYSICIANS

Steven A. Harrison, M.D.*
Bert F. van Beever, M.D.
Veronique Fernandez-Salvador, M.D.
*Board Certified

AUTHORIZATION & PAYMENT AGREEMENT

When assignment is accepted, I hereby authorize payment directly to Florida Urology Physicians, for benefits (including Medicare benefits or major medical) payable under the terms of my insurance or governmental coverage for any services furnished me by Florida Urology Physicians.

Upon receipt of a written request for release of medical information, I hereby authorize Florida Urology Physicians to release information acquired in the course of my examination or treatment.

I hereby authorize any physician, hospital, or medical care facility to provide information on my medical history and treatment to Florida Urology Physicians.

I hereby authorize any holder of medical or other information about me to release to the Social Security Administration and/or the State of Florida or their intermediary or fiscal agent any information needed for Medicare claims.

I hereby authorize Florida Urology Physicians, to receive "Explanation of Medicare Benefits" advisements for non-assigned Medicare claims on my behalf directed from the Medicare intermediary.

I hereby certify that the information given by me in applying for payment under the Medicare programs is correct.

I hereby authorize photocopies of this form to be as valid as the original.

I hereby agree to be responsible for the payment of this patient's account.

PATHOLOGY CONSENT: I hereby authorize the physicians of Florida Urology Physicians, to order pathology testing they deem necessary in connection with office visits or surgeries.

OUR PAYMENT POLICY* PLEASE NOTE

You are responsible directly to the office for payment of your account regardless of the status of medical or liability insurance claims. Office charges should be paid on the date incurred. All other charges are payable within 60 days, unless you arrange an extended payment plan. Accounts with charges 60 days or older will be subject to a rebilling fee. The undersigned hereby obligates him/her to pay the account for medical services rendered. If this account is referred to an attorney or collection agency for collection, the undersigned shall pay for reasonable attorney's fees, collection expenses, court costs and recording fees.

Upon request special consideration may be extended in the event of hardship. To avoid misunderstandings we invite you to discuss problems with our practice manager.

Standardized insurance forms are completed as a courtesy to you without charge. The office does not accept responsibility for collecting your insurance claims or negotiating settlement on a disputed claim.

**The guidelines, regulations, and policies regarding the receipt of payment from Medicare or Medicaid are applicable on my Medicare or Medicaid claim where the office accepts assignment of benefits. If you have a question or need further explanation on Medicare or Medicaid payments, Please let us know.*

DATE

SIGNATURE OF PATIENT AND/OR GUARANTOR

7451 Gladiolus Drive • Suite A • Fort Myers, Florida 33908 • 239-689-8800 • Fax 239-939-9255
1255-2 Viscaya Parkway • Suite 201 • Cape Coral, Florida 33990
3501 Health Center Boulevard • Suite 2130 • Bonita Springs, Florida 34135
1154 Lee Boulevard • Suite 1 • Lehigh Acres, Florida 33936
14651 Palm Beach Boulevard • Suite 100 • Fort Myers, Florida 33905
100 Madrid Boulevard • Suite 512 • Punta Gorda, Florida 33950