ADVANCED UROLOGY, INC.

_____ _____ _____
First Name M.I. Last Name

Date of Birth:_____ Social Security #_____

ASSIGNMENT OF BENEFITS

In consideration of any medical care provided to the above-named patient, I assign to Advanced Urology, Inc. and its physicians all my rights to any and all medical insurance benefits to which I am or may be entitled by any health plan.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Advanced Urology, Inc. and its physicians to disclose individually identifiable health information created or received by Advanced Urology, Inc. and its physicians, whether oral or recorded in any form of medium, regarding the above-named patient to any health plans that may be responsible for providing or paying the cost of rendered services in order to carry out payment activities.

GUARANTEE OF PAYMENT

I understand that I will be fully responsible for payment of any and all charges not covered by medical insurance at the current rates established by Advanaced Urology, Inc. for all services rendered the above-named patient.

I hereby further agree that I shall be responsible for any expense of Advanced Urology, Inc. in collecting the amounts guaranteed hereby, including all court costs, reasonable attorney's fees and other collection expenses.

X_____ _____
Signature of Patient Date

X_____ _____
Signature of Legal Representative (if applicable) Legal basis on which consent is given by Representative