South Florida Surgical Specialists, LLC.

UROLOGY CARE SPECIALISTS

1601 CLINT MOORE ROAD, SUITE 195

BOCA RATON, FL 33487

ASSIGNMENT OF BENEFITS/RIGHT TO PAYMENT AUTHORIZATION, PATIENT RESPONSIBILITY, AND RELEASE OF INFORMATION FORM

I, the undersigned, assign to the provider/entity referenced above (“Provider”), my rights and benefits in any medical insurance plan, health benefit plan, or other source of payment for healthcare services (each a “Plan”) in connection with medical services provided by Provider, its employees and agents. I understand that this document is a direct assignment of my rights and benefits under my Plan.

I authorize my insurance company to pay Provider directly for the professional or medical expense benefits payable to me. If my current policy prohibits direct payment to Provider, I instruct my insurance company to make out the check to me and mail it directly to the address of lockbox referenced above for the professional or medical expense benefits payable to me under my Plan as payment towards the total charges for the services rendered. In addition, I agree and undertand that any funds I receive by my insurance company due for services rendered by Provider are owed to Provider and I agree to remit those funds directly to Provider.

Patient Responsibility

I acknowledge and agree that I am responsible for all charge for services provided to me which are not covered by my Plan or for which I am responsible for payment under my Plan. To the extent no coverage exists under my Plan, I acknowledge that I am responsible for all charges for services provided and agree to pay all chargess not covered by my Plan.

Release of Information

I authorize Provider and/or its agents to release any medical or other information about me in its possession to my Plan, the Social Security Administration, any state administrative agency, or their intermediaries or fiscal agents required or requested in connection with any claim for services rendered to me by Provider.

A photocopy of this Assignment/Authorization shall be considered as effective and valid as the original.

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Signature of Patient/Person Legally Responsible — Date

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Print Name of Patient/Person Legally Responsible — Date

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Relationship to Patient (if signed by Person Legally Responsible) — Date