

To fill out document:  
Click on field, type information, then print.  
-OR-  
Print out document, then fill in fields with black ink only.

## Permissions, Consents, and Responsibilities

**Patient Name:** \_\_\_\_\_

**Consent to Treat:** I hereby authorize and consent to the performance of examinations, diagnostic procedures, and treatments which my physician and I agree are necessary. I understand that no guarantee has been made as to the results of the care, treatment and/or medications given to me. This consent shall remain in effect until I choose to revoke it in writing.

**Release of Information and Assignment of Benefits:** I understand that I am responsible for any fees for service rendered for myself and/or for my children(if applicable). I hereby authorize Uropartners to release any medical information to my insurance carrier concerning all conditions including those that may reference drug abuse, alcohol abuse or mental illness in order to process any claims on my behalf. I hereby assign to Uropartners payments made by my insurance carrier.

**Contracted Laboratory:** Uropartners will send lab tests to the Uropartners Laboratory and several other local labs. I understand that if my insurer mandates that I use a contracted lab, I must supply Uropartners with the name of that lab. If the contracted lab name is not supplied by me, my benefit level may be reduced when the test is submitted to Uropartners or an undesignated lab. If our Uropartners office does not work with the lab required by your insurer, it may be necessary to have your labs drawn at the outside lab. I also understand that it is my responsibility to notify Uropartners of any changes in my contracted laboratory.

Name of Laboratory: \_\_\_\_\_

\_\_\_\_\_

Initials/Date

**Authorization to Discuss My Account:** I hereby authorize the staff of Uropartners to discuss appointment information, test results and financial information with the following named person: \_\_\_\_\_

\_\_\_\_\_

**Commitment to Your Care:** I understand that in order to have an effective doctor-patient relationship it is my responsibility to be compliant with the physician's treatment recommendations and office policies. I understand that I may terminate this relationship at any time and request my records to transfer my care to another urologist. I further understand that the Uropartners' physicians may terminate the doctor-patient relationship at any time by giving 30-day written notice.

**Privacy Notice:** I hereby give my consent to Uropartners to use or disclose, for the purpose of carrying out treatment, payment or health care operations, all information contained in my patient record. I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so, to the physician. I also understand that I will not be able to revoke this consent in cases where the physician has already relied on it to use or disclose my health information. I acknowledge that I have received the Uropartners Notice of Privacy Practices brochure or have received it on a prior visit.

\_\_\_\_\_  
Signature of Patient or Responsible Party (indicate relationship if not patient)

\_\_\_\_\_  
Date