UROLOGY SAN ANTONIO

PATIENT CONSENT STATEMENTS

REV. 8/9/2013

Treatment Consent

I request and authorize medical and/or surgical treatment, as may be deemed necessary and appropriate by the physician and his or her designees participating in my care. The possible risks and benefits of any procedures shall be disclosed to me. This care may include diagnostic; radiology and laboratory procedures; therapeutic procedures, including minor procedures like cystoscopies (using a scope to examine the bladder); administration of drugs; hospital care and medically-appropriate referral for medical supplies including to companies in which my provider may be an investor. I realize that I have the right to informed participation in all decisions involving my health care. I acknowledge that no guarantees may be made in regard to the effectiveness of any particular treatment.

Financial Policy Consent

Please be advised that the eligibility and benefit information supplied by your insurance is only an estimate and not a guarantee of payment. Actual benefits are subject to all plan terms, definitions, limitations and exclusions in effect on the date of service. Urology San Antonio will submit your bill to your insurance for services performed by our medical providers at our medical facilities; however, it is ultimately the patient's responsibility to pay for any and all services provided. Please verify participation with your insurer prior to scheduling diagnostic, ancillary or specialty care conducted outside Urology San Antonio. Urology San Antonio is not responsible for verifying benefits for hospitals, anesthesia or any other outside ancillary services or facilities.

Confidential Communications Consent

I hereby authorize Urology San Antonio to furnish information to insurance carriers concerning my illness and treatment and hereby assign to the medical provider all payments for medical service rendered to myself or my dependents. I understand that Urology San Antonio may use electronic or facsimile communication devices to share information about me with other health care providers, third party payers or other facilities involved in my care. Urology San Antonio may leave voice mail identifying me as a patient of Urology San Antonio. (If you do not wish us to leave voice mail, please notify us.) Please understand that the use of communication technology may expedite you care. Urology San Antonio will not use or disclose your health care information without your authorization except as described in the Notice of Privacy Practices.

Signature on File

My signature below indicates my acknowledgement that I have read and agreed to the above.

_____ _____

Patient or Patient's Guardian Signature Date

_____

Patient or Patient's Guardian Printed Name

_____ _____

Witness' Printed Name Date

FOR OFFICE USE ONLY
Patient Account Number_____