UroHealth PARTNERS

Authorization and Consent Form

A. Authorization To Treat

I authorize and direct my physician and his/her designee to provide medical services and diagnostic services for me as they deem necessary and appropriate including but not limited to services involving laboratory, pathology and radiology. I understand that I have the right to receive information, to ask questions and to receive answers to my questions about my treatment plan. I also have the right to refuse treatment and to seek a second opinion.

B. Assignment of Insurance Benefits

I hereby assign all medical and /or surgical health insurance benefits, to which I am entitled, including Medicare, private insurance and any other health plans to the physician caring for me. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether or not paid by my insurance. I have reviewed and signed the Financial Responsibility Consent Form.

C. Patient Rights and Responsibilities

UroHealth Partners has established a Patient's Bill of Rights, I agree that I have received and understand my rights as a patient.

D. Medicare Coordination of Benefits Assessment

Medicare recommends that we ask the following questions of all our patients so that we can screen for patients with Medicare for primary or secondary benefits. We appreciate your time in completing these questions.

1. Are you or your spouse currently employed? **YES OR NO**
   If yes then:
   Do you have group health coverage based on your own or a spouse's current employment? **YES OR NO**
2. Are you entitled to Medicare because of disability or End Stage Renal Disease? **YES OR NO**
3. Is this illness or injury the result of an automobile accident or other injury? **YES OR NO**
4. Is this illness or injury the result of an accident or illness that occurred at work: **YES OR NO**
5. Has treatment and payment for this accident or illness been authorized by the Veteran's Administration? **YES OR NO**
6. Are you entitled to any benefits under the Federal Black Lung Program? **YES OR NO**

The undersigned patient or patient's guardian hereby acknowledge that I have read, understand and agree to conditions set forth in the:

A. Authorization to Treat
B. Assign of Insurance Benefits
C. Patient Rights and Responsibilities

As a Medicare recipient, if applicable, I have completed Section F accurately and to the best of my ability.

_____
Printed Patient Name, Guardian, or Medical Power of Attorney

_____ _____
Signature of Patient, Guardian or Medical Power of Attorney Date