Patient Name: _____

Account: _____ Date: _____

SIGNATURE AND RELEASE AUTHORIZATION

CONSENT TO EXAMINATION AND TREATMENT: attested by my signature on this form, I hereby consent to allow physicians and medical staff of Gainesville Urology to examine and treat me (or the person named herein for whom I have legal responsibility) in connection with my visit to Gainesville Urology.

_____ 1. _____

Date Signature of Patient or Guardian

SURGERY CENTER, RADIOLOGY, AND LABORATORY INTERPRETATION AND TESTING SERVICES: Gainesville Urology Ambulatory Surgery Center is owned and operated by Gainesville Urology physicians. Radiology and laboratory services are provided independently by physicians who are not Gainesville Urology agents or employees, and who bill separately from Gainesville Urology for their services.

FINANCIAL RESPONSIBILITY AND RELEASE OF INFORMATION: I understand that **I am financially responsible to Gainesville Urology**, P.C. for charges not covered by my insurance carrier. Payment for services is due at time of service unless prior arrangements have been made. **I also agree** that, should I fail to assume this financial responsibility and credit action is necessary, **I will pay for these costs** in addition to the amount of the doctor's charges**. I authorize** Gainesville Urology, P.C. to release to the Social Security Administration or its intermediaries or carriers, or other insurance carrier any medical or other information needed for this or a related insurance claim. A copy of this authorization may be used in place of the original. **Continued treatment of my condition(s) may be refused if I fail to pay for services rendered.**

_____ 2. _____

Date Signature of Patient or Guardian

CO-PAYMENTS: our contract with your insurance company requires that we collect co-payment at time of service. If the co-payment is not paid at time of the visit, Gainesville Urology will add an appropriate charge to cover the additional cost of billing.

INSUFFICIENT FUNDS CHECKS: Gainesville Urology will bill the patient $20 in addition to the amount of the check.

EXTENDED PAYMENT REQUEST (ONE TIME AUTHORIZATION): I request that payment of any authorized insurance or other benefits be made on my behalf to Gainesville Urology, P.C. for any services furnished me by that provider. This one time signature will be maintained on file as verification for all subsequent services, which are provided to you by this provider. **I authorize** any holder of medical information about me to release to the Health Care Financing Administration and its agent or other insurance carriers any information needed to determine these benefits or the benefits payable for related services.

_____ 3. _____

Date Signature of Patient or Guardian

NOTICE OF PRIVACY ACKNOWLEGEMENT: We keep a record of the health care services we provide you. You may ask to see, copy, or correct that record. Except for when our staff and physicians must exchange patient information to provide continuity of care, or for billing purposes, we will not disclose your record to others unless you authorize us to do so, or the law compels us. You may request to see your record by contacting the Administrator. Our Notice of Privacy Practices (available in our waiting room and in smaller printed form) will describe in more detail how your health information may be used and disclosed, as well as how you may access your information.
I also authorize the release of lab, x-ray, CT and other relevant diagnostic reports to Gainesville Urology for use in connection with my diagnosis and treatment.

_____ 4. _____

Date Signature of Patient or Guardian

_____

Printed name/relationship if signed on behalf of patient