Southwest Urology
Consent for purposes of Treatment, Payment and Healthcare Operations

I consent to the use or disclosure of my protected health information by Southwest Urology for the purpose of diagnosing, or providing treatment of me, obtaining payment for my health care bills or to conduct health care operations of Southwest Urology, Inc. To the extent available, Southwest Urology may obtain prescription information and send prescription information electronically to assist in my medical treatment.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed. Southwest Urology, Inc. is not required to agree to the restrictions that I may request. However, if Southwest Urology, Inc. agrees to a restriction that I request, the restriction is binding on Southwest Urology.

I have the right to revoke this consent, in writing, at any time, except to the extent that Southwest Urology has taken action in reliance to this consent. This authorization will be in effect until it is revoked or terminated by the patient or patient's representative. You may revoke or terminate this authorization by submitting a written revocation to Southwest Urology to the attention of the Privacy Officer or by calling 440-887-2784.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer, or a health clearinghouse. This protected health information relates to my past, present, or future physical or mental health condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Southwest Urology Privacy Notice prior to signing this document. The Privacy Notice describes the types of uses and disclosures or my protected health information.

Southwest Urology reserves the right to change the privacy practices that are described in the Privacy Notice. I may obtain a revised privacy notice by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

With this consent, Southwest Urology may call my home or alternative location and leave a message on voice mail or with an individual in reference to any items that assist the practice in fulfilling treatment, payment, and healthcare operations, such as appointment reminders, insurance items, and any calls pertaining to your care, including test results.

With this consent, Southwest Urology may mail to my home or alternative location any items that assist the practice in fulfilling treatment, payment and healthcare operations. I have received the NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION and understand that my protected health information may be used by the Practice as described in the notice.

1) I wish to receive reminder/confirmation calls for appointments at _____ (telephone number) ☐ Yes ☐ No
2) May we leave a message at your home with other residents? ☐ Yes ☐ No
3) If you have an answering machine, may we leave a message on the machine? ☐ Yes ☐ No
4) Do you wish your mail sent to an alternate address? ☐ Yes ☐ No

   List Address: _____

5) Who may we speak with regarding your medical concerns: _____

Name of Patient (Print) _____

Signature (Patient or Representative)_____

Date Signed_____ Representative's relationship to patient _____

Payment Authorization/General Consent for Treatment

Medicare/Medicaid: I authorize the release of any medical or other information needed to process any claims on my behalf. I also request payment of government benefits either to myself or to the party who accepts assignment. I authorize payment of medical benefits to SouthWest Urology, Inc. for services rendered.

All other Insurance Companies and/or Third Party Payers: I **hereby authorize**, SouthWest Urology and/or any of its representatives to submit a claim to my insurance carrier or its intermediaries for all services rendered by the physician(s) and other health care professionals and authorize and direct my insurance carrier or its intermediaries to issue payment directly to SouthWest Urology for rendering services. I authorize the release of any medical or other necessary information to my insurance carrier to its intermediaries regarding services rendered.

Guarantee of Payment: I understanding that filing a claim with my insurance company or other third party payers, under any circumstances, does not relieve me from my responsibility for the payment of all charges. I further acknowledge that I am responsible for the payment of all charges for services rendered by SouthWest Urology to me or to the patient as indicated. By signing this document, I personally guarantee the payment of these charges for medical services rendered. This includes, but is not limited to, claims filed for Worker's Compensation and/or claims due to personal injury, accident/illnesses.

General Consent to Treatment: Having come to SouthWest Urology for evaluation or treatment, I (or my authorized representative on my behalf) hereby consent to and authorize the physicians and other staff members involved in my care to administer such diagnostic procedure, treatment, or both as they may consider advisable to maintain my health and to assess and to evaluate and treat my injury or illness. I understanding that the provider responsible for my care has the responsibility to explain to me the purpose, the benefits and the most common risks involved in the diagnosis and treatment of my illness or injury, as well as alternative available courses of treatment, and I understand that I have the right to refuse any suggested examination, test, or treatment.

Right to refuse treatment: In giving my general consent to treatment, I understanding that I retain the right to refuse any particular examination, test, procedure, treatment, therapy, or medication recommended or deemed medically necessary by my individual treating health care providers. I also understand that the practice of medicine is not an exact science and that no guarantees have been made to me as to the results of my evaluation and/or treatment.

Printed Name of Patient/Guardian _____

_____ _____

Signature **Date Signed**