Texas Center for Urology

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PATIENT REGISTRATION FORM DISCLOSURES & CONSENTS

Patient Name: _____
Last Name First Name Date of Birth

ASSIGNMENT OF INSURANCE BENEFITS:
I hereby authorize direct payment of my insurance benefits to Texas Center for Urology or the physician individually for services rendered to my dependents, or me, by the physician or those under his/her supervision. I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are a covered benefit. I understand and agree that I will be responsible for any deductible, co-insurance, co-pay or balance due that Texas Center for Urology is unable to collect from my insurance carrier for whatever reason.

MEDICARE/MEDICAID/CHAMPUS INSURANCE BENEFITS:
I certify that the information given by me in applying for applying for payment under these programs is correct. I authorize the release of any of my or my dependent's records that these programs may request. I hereby direct that payment of my or my dependent's authorized benefits be made directly to Texas Center for Urology or the physician on my behalf.

AUTHORIZED TO RELEASE NON-PUBLIC PERSONAL INFORMATION:
I certify that I have read and been offered a copy of the Texas Center for Urology "HIPAA & Notice of Privacy Practices." I hereby authorize Texas Center for Urology or the physician individually to release any of my or my dependent's medical or incidental nonpublic personal information that may be necessary for medical evaluation, treatment, consultation, or the processing of insurance benefits.

AUTHORIZATION TO MAIL, CALL OR E-MAIL:
I certify that I understand the privacy risks created by the use of the U.S. mail, telephone calls, faxes and e-mail. I hereby authorize a Texas Center for Urology representative or my physician to mail, call, fax or e-mail me with communications regarding my healthcare, including but not limited to such things as appointment reminders, referral arrangements and diagnostic test results. I understand that I have the right to rescind this authorization at any time by notifying Texas Center for Urology to that effect in writing.

LAB/X-RAY/DIAGNOSTIC SERVICES:
I understand that I may receive a separate bill if my medical care includes lab, x-ray, or other diagnostic services performed by third party vendors. I further understand that I am financially responsible for any co-pay or balances due for these services if they are not reimbursed by my insurance for whatever reason.

CONSENT FOR TREATMENT:
I hereby consent to evaluation, testing and treatment as directed by my Texas Center for Urology physician or those under his/her supervision.

PATIENT SIGNATURE: _____ DATE: _____

GUARANTOR SIGNATURE: _____ DATE: _____

GUARANTOR NAME (Please Print) _____