FORE RIVER UROLOGY

Patient Name_____ Patient Date of Birth_____
Patient Medical Record #_____

General Consent for Treatment ▪ Assignment of Benefits
Patient Responsibility for Payment

I, the undersigned, being either the patient or the patient's legally authorized representative, do hereby:

GENERAL CONSENT FOR TREATMENT

- Consent to such routine diagnostic procedures and to medical and/or surgical treatment and/or evaluation, including but not limited to laboratory and imaging (ultrasound) examinations by my treating physician and/or his/her assistance and or designees as are necessary and desirable in the exercise of professional judgment.
- Understand that separate consents will be requested for certain special procedures.
- I understand that Fore River Urology requires my treating physician to give me a general explanation of the procedures or treatments and of the usual and most frequent risks and hazards inherent in the proposed procedures or treatments.
- Consent to Fore River Urology and its authorized employees or agents to release information about me contained in my medical records to physicians and others responsible for follow-up care, and to disclose to third-party payor(s) and their agents, including my employer, only that information concerning my status as a patient and my treatment as is reasonable and necessary for the discharge of the legal or contractual obligation(s) of the third-party payor(s). The purpose of this release is to provide the third-party payor(s) with sufficient information to allow for payment for the part of my treatment for which they are obligated to pay.

ASSIGNMENT OF BENEFITS

- Assign all benefits under any insurance or health benefit plan for payment for medical services rendered by Fore River Urology to Fore River Urology and further agree to remit payment to Fore River Urology within thirty days of any benefits paid directly to me.

PATIENT RESPONSIBILITY FOR PAYMENT

- Accept financial responsibility for any amount not paid by insurance or other heath benefit plans.

REQUIRED FORMS

- I have received a copy of the Fore River Urology "Notice of Privacy Practices" which includes information about my patient rights and responsibilities. I understand that it is my responsibility to read the information, and ask any questions that I may have. I further understand that current copies of this document will be maintained in the Patient Education area at all times for my review and are also available upon request.
- I understand this document remains in effect for as long as I continue to visit Fore River Urology, unless specifically rescinded in writing.

_____ _____

Patient Signature **Date**

_____ _____

Legally Authorized Representative **Date**

For Legally Authorized Representatives ONLY:
Relationship_____ Reason: _____ Minor Patient _____Other/POA