STARKVILLE
UROLOGY

PATIENT CONSENT AND AUTHORIZATION FORM

Patient Name: _____ Date of Birth: _____

Address: _____ Phone #: _____

Consent for Treatment

The undersigned authorizes the physician assigned to furnish medical and/or surgical treatment of those means he/she considers necessary and proper treatment of the patient identified below while a patient of Starkville Urology. This consent includes examination and treatment by the physicians, nurses, and other health care professionals at Starkville Urology. I also consent to any medical procedures, CT scans, Urodynamics, Ultrasound, laboratory tests and/or other health care services ordered by Starkville Urology. I understand that I may refuse specific treatments or procedures by informing a health care professional of such refusal.

Confirmation of Appointments:

As a courtesy to you, we do call and text prior to your appointment to confirm the time and date of your appointment. This information cannot be left on your voicemail or answering machine or related to someone else without written permission. The undersigned authorizes Starkville Urology to leave appointment reminder information by voicemail, answering machine or with the person who may answer my phone number.

Medical Records:

Medical records cannot be sent to your primary care physician or referring provider without written permission from you. The undersigned authorizes Starkville Urology to disclose my patient information and medical record to the physician(s) or provider(s) listed on my patient registration form. I understand that I may revoke this authorization, except to the extent that action has already been taken, in writing at any time by sending written revocation of authorization to Starkville Urology.

Acknowledgement of Notice of Privacy Practices:

By my signature below, I verify that I have been given the HIPAA Notice of Privacy Practices, which provides me with the information of how my Protected Health Information (PHI) is used.

Test Results:

Test results cannot be left on your voicemail or answering machine or discussed with another family member, even your spouse, without your written permission. The undersigned authorizes that Starkville Urology may leave information regarding test results with the following individual(s):

Name of Person: _____ Phone Number: _____ Relationship to Patient: _____

Name of Person: _____ Phone Number: _____ Relationship to Patient: _____

Patient (or Guardian) Signature: _____ Date: _____

Printed Name of Patient (or Guardian): _____

STARKVILLE
UROLOGY

FINANCIAL AND INSURANCE POLICIES

Patient Name: _____ Date of Birth: _____

Address: _____ Phone #: _____

You must pay your copay and any coinsurance at each visit. You must pay any deductible or coinsurance BEFORE any office procedure or surgery is performed. Starkville Urology participates in the Medicare and Mississippi Medicaid programs as well as other commercial insurance products. We do not participate in most HMO plans.

If the clinic participates in your insurance plan, you will be responsible for all copays, deductibles, and coinsurance amounts at the time of service. You will also be responsible for any services not covered by your insurance plan. **You must bring your insurance card(s) to every visit.**

If the clinic does not participate in your insurance plan, you will be considered Self Pay. You will be required to pay $295.00 deposit on your first visit which will be applied to your charges. If you have any questions regarding the networks we participate in, please ask prior to being seen.

If you do not have any insurance, you will be required to pay a $295.00 on your first visit. This must be paid before you are seen. All future charges should be paid at time of service unless you work out other payment arrangements with our billing staff.

You understand that you are financially responsible for all clinic charges unless covered and paid by your third-party insurance as explained above. If you should default on your financial responsibility, you understand that your account may be turned over to a collection agency. If this occurs, you may be charged for all reasonable collection fees incurred by the clinic. You consent to receive communications regarding your account from the clinic or its collectors by any phone number(s) you provide including cell, employer, and home landline numbers.

The clinic reserves the right to charge patients a no-show fee of $100.00 who continually do not show up for appointments.

The clinic reserves the right to charge patients a fee of $25.00 for returned checks.

Assignment of Benefits

Medicare and Medicaid: You hereby request that the payment of authorized Medicare/Medicaid benefits for services rendered by the clinic on your behalf, shall be made to the clinic, and you specifically assign such benefits to the clinic. You hereby certify that all information given by you in connection with applying for such benefits is correct and complete in all respects. You understand that payment for certain services not deemed medically necessary by Medicare/Medicaid are not authorized under the Medicare/Medicaid Programs to pay all copays, coinsurance, and deductibles upon demand by the clinic, including at the time of service.

Commercial Insurance: You hereby assign to the clinic all rights, benefits, and interest under any insurance policy, health plan, or workers compensation plan in consideration for services rendered by the clinic. You hereby authorize payment of such benefits directly to the clinic for treatment you receive by the clinic. You understand that you are required to pay all copays, coinsurance, and deductibles upon demand by the clinic, including at the time of service.

I agree that in the event of non-payment for services provided, I accept full and complete responsibility for the balance due, collection costs, court costs, as well as any attorney fees should legal action become necessary. I authorize the use of my signature on all insurance submissions.

Discussion of Your Account/Payment Responsibility:

We cannot discuss your bill with anyone without written permission, including your spouse or any other family member, unless they have a power of attorney on file. By my signature below, I give Starkville Urology permission to discuss billing information with the following individual(s):

Name of Person: _____ Phone Number: _____ Relationship to Patient: _____

Name of Person: _____ Phone Number: _____ Relationship to Patient: _____

Consent to Release Health Information for Billing and Payment Purposes:

You hereby consent to the release of your health information by the clinic for the purpose of obtaining authorization and payment of services rendered to you by the clinic. Your consent does NOT waive your privacy rights under federal law (known as the Health Insurance Portability and Accountability Act, or HIPAA).

Patient (or Guardian) Signature: _____ Date: _____

Printed Name of Patient (or Guardian): _____