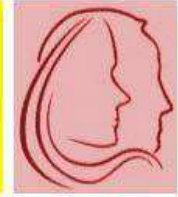




**Urology**  
Clinic P.C.



STACY J. CHILDS, M.D., F.A.C.S.  
JAMIE VANOVEREN, D.O.

## **CONSENT TO TREATMENT-FINANCIAL RESPONSIBILITY**

### **CONSENT TO TREATMENT**

The undersigned patient/responsible party consents to the medical/ surgical procedure(s) and treatment(s), including but not limited to anesthesia, laboratory procedures, x-rays, and examinations to be rendered pursuant to the general and special instructions of my physician. This extends to the anesthesiologists, emergency physicians, pathologists, and radiologists, all of whom are independent contractors and not employees of Urology Clinic, P.C.

### **FINANCIAL RESPONSIBILITY**

By accepting any medical services or treatment, including but not limited to consultations, examinations, x-rays, and surgery, the undersigned patient/ responsible party agrees to pay Urology Clinic, P.C. all charges for such service or treatment.

Fees and interest charges may be added on to the account if payment for services is delinquent and an outside collections agency is required. The amount of the fees and interest charges will vary and is dependent on what Urology Clinic, P.C. deems necessary to collect funds.

### **INSURANCE AUTHORIZATION AND ASSIGNMENT**

**I am aware that as a courtesy my primary insurance will be billed. It is my responsibility to follow up on any delinquent claims.**

I hereby authorize Urology Clinic, P.C. to furnish information to insurance carriers concerning myself or my dependents' illness or treatments. I assign the insurance benefits to Urology Clinic, P.C. and authorize and direct my insurance carrier to pay those benefits directly to Urology Clinic, P.C. I authorize Urology Clinic, P.C. to release medical information to other physicians when deemed necessary for my medical treatment. I understand that if my medical insurance does not pay for any reason it will be my responsibility to pay the bill in full, unless prohibited by law.

If Tricare, Medicare, Medicaid, Workman's Compensation, or similar government programs should determine that I am *not* eligible for coverage or that the service or treatment is *not* covered, I will be responsible for payment unless prohibited by law.

### **AUTHORIZATION TO RELEASE INFORMATION**

The undersigned patient/ responsible party authorizes Urology Clinic, P.C., to disclose financial and medical information and records to: my employer and third-party payers, who are or may be responsible for payment of all or a portion of the charge; to other health care and/or to the referring physician to ensure continuity of medical care; and for purposes of accreditations, audits, certification, and peer or utilization reviews.

### **NOT RESPONSIBLE FOR PERSONAL PROPERTY**

Patients should not bring valuables to this facility. Urology Clinic, P.C. is not responsible for any personal property brought into or left in the facility.

**BY SIGNING THE PATIENT INFORMATION FORM PATIENT/RESPONSIBLE PARTY  
ACKNOWLEDGES THAT THEY HAVE HAD THE OPPORTUNITY TO READ THIS FORM, AND  
AGREES TO THE TERMS SET FORTH IN THIS FORM**