UROLOGY PARTNERS

Patient's Name (First, Middle, Last): _____

Address: _____

City:_____State:_____Zip Code:_____

Main Contact#:_____Alternate#:_____Work#: _____

Email: _____

Date of Birth:_____/_____/_____ Sex: ◯ Male ◯ Female SS# (optional): _____

Marital Status: ◯ Single ◯ Married ◯ Divorced ◯ Widowed Occupation: _____

Spouse's Name: _____

Spouse's Date of Birth:_____/_____/_____ Main Contact#: _____ Alternate#: _____

Emergency Contact:_____Relationship:_____Phone#: _____

Primary Care Physician:_____Phone#:_____

Referring Physician:_____Phone#:_____

Which racial category does the patient most closely identify with?

◉ African American ◯ Asian ◯ Caucasian ◯ Hispanic

◯ Native American ◯ Native Hawaiian ◯ Pacific Islander ◯ Other:_____(Please Specify)

Ethnicity: What is the patient's ethnicity? ◯ Hispanic or Latino ◯ Not Hispanic or Latino

What is the patient's language of preference? ◯ English ◯ Spanish ◉ Other:_____(Please Specify)

********** INSURANCE INFORMATION **********

Primary Insurance:_____Policy/ID# _____

Name of Policy Holder:_____DOB:_____/_____/_____Group/Acct #:_____

Employer:_____Employer Address: _____

City: _____ State: _____ Zip Code:_____Work #: _____

Secondary Insurance:_____Policy/ID#: _____

Name of Policy Holder:_____DOB:_____/_____/_____Group/Acct #:_____

Employer:_____Employer Address: _____

City: _____ State: _____ Zip Code:_____Work #: _____

UROLOGY PARTNERS

HISTORY OF PRESENT ILLNESS

Today's Date: _____

_____ _____ _____ _____/_____/_____
Last Name First Name M.I. Date of Birth

Whom may we thank for referring you to UPNT? ☐ Self ☐ Friend ☐ Physician: _____

Primary Care Physician: _____ Prior Urologist: _____

REASON FOR VISIT: _____

- ☐ Elevated PSA
- ☐ Erectile dysfunction
- ☐ History of bladder cancer
- ☐ Vasectomy
- ☐ Kidney stones
- ☐ History of kidney cancer
- ☐ Urinary tract infections
- ☐ Infertility
- ☐ History of prostate cancer
- ☐ Abdominal or flank pain

Blood in urine: ☐ Visible ☐ Invisible

- ☐ BPH or male voiding symptoms or Incontinence or female voiding symptoms
- ☐ Other (please specify): _____

What is the approximate date when the symptoms started or you first became aware of the problem?

Date: _____ or _____ ☐ days ☐ weeks ☐ months ☐ years ago

Describe any previous treatment (medicines, surgeries, etc.) prior to this visit for the problem: _____

_____

_____

ALLERGIES

(Include medications, foods, and/or x-ray dyes, etc.) **or** ☐ **NONE KNOWN**

Name of allergen	Type of reaction
1	
2	
3	

CURRENT MEDICATIONS

(Include prescription, over the counter, and herbal medications. Attach extra sheet if necessary.) **or** ☐ **NONE**

Name of Medication	Dose (mg)	How often is the medication taken?	Reason for taking medication?	Physician prescribing
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				

UROLOGY PARTNERS

HISTORY OF PRESENT ILLNESS

Patient Initials: _____

PHARMACY **(List pharmacy most frequently used for prescriptions)**

Name:_____ Phone #:_____ Fax #: _____

Address:_____ City:_____ State/Zip:_____

MEDICAL CONDITIONS **(Include past and present medical conditions, check appropriate box)**

Condition	YES	Resolved	Date Onset	Specialist MD (if applicable)
Asthma				
Bleeding Problems				
Cancer of any organ (specify)				
Congestive heart failure				
Diabetes				
Elevated cholesterol				
Emphysema, COPD, or lung problems				
Glaucoma				
Heart attack				
High blood pressure (hypertension)				
HIV/AIDS				
Irregular heartbeat				
Kidney disease (renal failure)				
Kidney stones				
Liver disease (hepatitis B or C)				
Psychological or psychiatric disease				
Seizures				
Stroke or TIA				
Thyroid disease				
Ulcers of the stomach or intestine				

Have you had any other major medical conditions not noted above? If so, please list: _____

_____

PAST SURGERIES **(Include all surgeries in your lifetime. Attach extra sheet if necessary.)** **or** ☐ **NONE**

Type of Surgery	Date (approximate)	Hospital or City if known
1		
2		
3		
4		
5		
6		

UROLOGY PARTNERS

HISTORY OF PRESENT ILLNESS

Patient Initials: _____

OTHER HOSPITALIZATIONS (Include all non-surgical hospitalizations) or ☐ NONE

Reasons for Hospital Stay	Date (approximate)	Hospital or City if known
1		
2		
3		
4		
5		

FAMILY HISTORY

Is there a history in your family of:	No	Yes	Affected relative(s)
Diabetes			
Heart attack			
Kidney cancer			
Kidney stones			
Prostate Cancer			
Other significant disease			

ALCOHOL HISTORY

Have you ever been diagnosed with alcoholism? ☐ Yes ☐ No

Do you currently drink alcohol regularly? ☐ Yes, currently ☐ Never/rarely

If yes, approximately how many drinks per week (beer, wine, or liquor)_____

DRUG HISTORY

Have you ever used intravenous drugs? ☐ Yes ☐ No

TOBACCO HISTORY

Are you an active cigarette smoker? ☐ Yes ☐ No

Have you ever been a cigarette smoker? ☐ Yes ☐ No

* If yes, I smoked an average of_____packs/day for_____years. I quit in_____(year)

Do you use other tobacco products? ☐ Yes ☐ No

* If yes, please specify:_____

DIET AND EXERCISE

Do you follow a special diet? ◯ Yes ◯ No If yes, please explain: _____

Do you exercise regularly? ◯ Yes ◯ No If yes, how many times per week: _____

What do you do most often for exercise? _____

PAIN ASSESSMENT

Do you have any pain? ◯ Yes ◯ No If yes, location of pain: _____

If so, please rate your average amount of pain on a scale of 0 (no pain) to 10 (excruciating pain): _____

SOCIAL HISTORY

Marital Status: ◯ Single ◯ Married ◯ Divorced ◯ Widowed

Occupation (If retired, previous occupation): _____

UROLOGY PARTNERS

HISTORY OF PRESENT ILLNESS

Patient Initials: _____

REVIEW OF SYSTEMS

(Current or Recent Symptoms)

Constitutional

Fever	☐ Yes	☐ No
Chills	☐ Yes	☐ No
Weight gain over 10 lbs.	☐ Yes	☐ No
Weight loss over 10 lbs.	☐ Yes	☐ No

Ear/Nose/Throat/Mouth

Hearing loss	☐ Yes	☐ No
Difficulty swallowing	☐ Yes	☐ No
Nose bleeds	☐ Yes	☐ No
Hoarseness	☐ Yes	☐ No

Respiratory (lungs)

Wheezing	☐ Yes	☐ No
Frequent coughing	☐ Yes	☐ No
Shortness of breath	☐ Yes	☐ No
Coughing up blood	☐ Yes	☐ No

Cardiovascular

Chest pain, pressure	☐ Yes	☐ No
Palpitations	☐ Yes	☐ No
Calf pain with exercise	☐ Yes	☐ No
Shortness of breath	☐ Yes	☐ No
Swelling in legs/ankles	☐ Yes	☐ No

Gastrointestinal

Abdominal Pain	☐ Yes	☐ No
Nausea vomiting	☐ Yes	☐ No
Diarrhea	☐ Yes	☐ No
Constipation	☐ Yes	☐ No
Blood in stools	☐ Yes	☐ No

Genitourinary (urinary and genital)
(Complete only if not the reason for your visit)

Painful urination	☐ Yes	☐ No
Frequent urination	☐ Yes	☐ No
Urgent urination	☐ Yes	☐ No
Blood in urine	☐ Yes	☐ No
Weak urine stream	☐ Yes	☐ No
Straining to urinate	☐ Yes	☐ No
Interrupted urine flow	☐ Yes	☐ No
Incontinence	☐ Yes	☐ No
Incomplete emptying	☐ Yes	☐ No
Erectile dysfunction	☐ Yes	☐ No

Hematologic/Lymphatic

Swollen lymph glands	☐ Yes	☐ No
Bleeding tendency	☐ Yes	☐ No

Endocrine (internal glands)

Excessive thirst	☐ Yes	☐ No
Cold or heat intolerance	☐ Yes	☐ No
Excessive fatigue	☐ Yes	☐ No
Thyroid disease	☐ Yes	☐ No

Immunizations

Did you receive a flu shot within the past year?
☐ Yes ☐ No Approx. Date: _____
Have you ever received a pneumonia vaccine?
☐ Yes ☐ No Approx. Date: _____

Musculoskeletal

Joint pain	☐ Yes	☐ No
Neck pain	☐ Yes	☐ No
Back pain	☐ Yes	☐ No
Muscle weakness	☐ Yes	☐ No

Integumentary (skin problems)

Unexplained rash	☐ Yes	☐ No
Frequent boils	☐ Yes	☐ No

Neurological (nervous system)

Seizures	☐ Yes	☐ No
Dizziness	☐ Yes	☐ No
Numbness in extremity	☐ Yes	☐ No
Frequent falls	☐ Yes	☐ No

Psychological

Depression	☐ Yes	☐ No
Severe anxiety	☐ Yes	☐ No

Eyes

Blurred vision	☐ Yes	☐ No
Double vision	☐ Yes	☐ No
History glaucoma	☐ Yes	☐ No
Untreated cataracts	☐ Yes	☐ No
Retinal disease	☐ Yes	☐ No

Height (inches) _____

Weight (lbs.) _____

_____
Patient Signature

NOTICE OF PROVIDER PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Urology Partners of North Texas, PLLC must maintain the privacy of your personal health information and give you this notice that describes our legal responsibilities and privacy practices concerning your personal health information. We must follow the privacy practices described in this notice. If you have any questions about this notice, please contact our Privacy Officer.

Our Obligations

We are required by law to:

- Maintain the privacy of your protected health information.
- Give you this notice of our legal duties and privacy practices regarding health information about you.
- Follow the terms of our notice that is currently in effect.

How We May Use And Disclose Health Information

The following describes the ways we may use and disclose health information that identifies you ("Health Information"). Except for the purposes described below, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our Privacy Officer.

For Treatment. We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care. We may also use your Health Information to obtain real-time prescription history information.

For Payment. We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company or a third party for the treatment and services you received. For example, we may give your health plan information about you so that they will pay for your treatment.

For Health Care Operations. We may use and disclose Health Information to include both demographic data and clinical information for health care operation purposes both internally and externally. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the obstetrical or gynecological care you receive is of the highest quality. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services. We may use and disclose Health Information to contact you to remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Special Situations

As Required by Law. We will disclose Health Information when required to do so by international, federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Organ and Tissue Donation. If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement, banking or transportation of organs, eyes or tissues to facilitate organ, eye or tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military command.

Workers' Compensation. We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; report a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities. We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and ensure compliance with civil rights laws.

Data Breach Notification Purposes. We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release Health Information if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct on our premises; and (6) in an emergency, to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We also may release Health Information to funeral directors as necessary for their duties.

National Security and Intelligence Activities. We may release Health Information to authorized federal officials for intelligence, counter-intelligence, and other national security activities as authorized by law.

Protective Services for the President and Others. We may disclose Health Information to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or to conduct special investigations.

Inmates or Individuals in Custody. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be if necessary: (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

Uses And Disclosures That Requires Us To Give You An Opportunity To Object And Opt Out

Individuals Involved in Your Care or Payment for Your Care. Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your Protected Health Information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

Disaster Relief. We may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practically can do so.

Your Written Authorization Is Required For Other Uses And Disclosures

The following uses and disclosures of your Protected Health Information will be made only with your written authorization:

1. Uses and disclosures of Protected Health Information for marketing purposes; and
2. Disclosures that constitute a sale of your Protected Health Information

Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose Protected Health Information under the authorization. Disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

Your Rights

Right to Inspect and Copy. You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing, to our Privacy Officer. We have up to 30 days to make your Protected Health Information available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state of federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.

Right to an Electronic Copy of Electronic Medical Records. If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your Protected Health Information in the form or format you request, if it is readily producible in such form or format. If the Protected Health Information is not readily producible in the form or format you request, your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

Right to Get Notice of a Breach. You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

Right to Amend. If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to our Privacy Officer.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to our Privacy Officer.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to our Privacy Officer. We are not required to agree to your request unless you are asking us to restrict the use and disclosure of your Protected Health Information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us "out-of-pocket" in full. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Out-of-Pocket-Payments. If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. To request confidential communications, you must make your request, in writing, to our Privacy Officer. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our web site. To obtain a paper copy of this notice, you must make your request to our Privacy Officer.

Disclosure of Ownership

As a patient of Urology Partners of North Texas, PLLC, your physician is required to inform you that Baylor Surgical Hospital at Las Colinas is partly owned by physicians and meets the federal definition of a "physician-owned hospital" as specified in 42 CFR 489.3. Your physician is one of the physician owners of Baylor Surgical Hospital at Las Colinas. You have the right to choose the provider of your healthcare services. Therefore, you have the option of using an alternative health care facility other than Baylor Surgical Hospital at Las Colinas. You will not be treated differently by your physician if you choose to use an alternative healthcare facility. If desired, your physician can provide you with information about alternative health care facilities. If you have any questions regarding the information contained in this Notice to Patients, please feel free to ask your physician. We welcome you as a patient and value our relationship with you.

Changes To This Notice

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office.

Complaints

You will not be penalized for filing a complaint. If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact our Privacy Officer. All complaints must be made in writing.

UROLOGY PARTNERS

HIPAA

I authorize Urology Partners of North Texas, PLLC, its assignees and third-party collection agents to use the contact information I have provided to communicate with me and to place calls to my home/cellular/ employment telephone, leave voice or text messages and use pre-recorded/artificial/voice/text messages and/or auto-dialing devices in connection with any communication to me. Furthermore, I authorize Urology Partners of North Texas, PLLC to discuss my/the patient's care and medical needs with the following persons:

Name	Date of Birth (for identification)	Relationship	Phone

Primary Phone #: _____

- ☐ Leave message with contact number only.
- ☐ Leave message with detailed information.
- ☐ Do not leave message.

Secondary Phone #: _____

- ☐ Leave message with contact number only.
- ☐ Leave message with detailed information.
- ☐ Do not leave message.

_____ _____

Patient/Guarantor Signature Date

_____ _____

Patient Name Patient Date of Birth

UROLOGY PARTNERS

Financial Policy

The following information is provided to avoid any misunderstanding concerning payment for professional services. All professional services rendered are charged to the patient. When supplied with complete insurance information, we will file your insurance for you. The patient is responsible for all fees regardless of insurance coverage. It is customary to pay for services when rendered unless prior arrangements have been made with our business office. All of our physicians are participating providers with Medicare, therefore, claims will be filed by Urology Partners of North Texas, PLLC and payment will be received at this office. A photocopy of this authorization and assignment shall be considered as valid as the original.

You understand that you are responsible for your account balance regardless of what any insurance pays. You hereby authorize Urology Partners of North Texas, PLLC to furnish information to my insurance carrier and/or attorneys concerning my illness and treatments. You hereby assign to Urology Partners all payments for medical services rendered to myself and/or my dependents.

- **Insurance cards must be presented at every visit.**
- As a courtesy, we will file your primary and secondary insurance. We do not file third insurance.
- All charges for treatment become due and payable within thirty (30) days after your insurance payer has evaluated and processed your claim at which time you are responsible for any remaining balance.
- We will require payment of your co-pay and/or deductible & applicable co-insurance at the time services are rendered.
- The patient acknowledges that it is the patient's responsibility to be aware of what services are covered and agrees to pay for any services deemed to be non-covered or not authorized by their plan(s).
- **Medicare** - We accept assignment. Please pay your 20% or allow us to file your supplemental policy. If you do not have a supplemental policy, we will ask you to pay the Medicare Deductible/Co-Insurance. Medicare and secondary carriers do not cover some procedures or supplies. Please make sure you understand which treatments and supplies are covered as you will be asked to sign a waiver stating that you understand when services are deemed not covered and you will be responsible for associated charges.
- **HMO's** – Please bring your referral number and your co-pay when you come for an office visit. It is the patient's responsibility to get referrals for visits. Patients seen without the requisite referral will be responsible for charges in full at the time of service.
- **Self Pay** – If you do not currently have insurance coverage, we ask that you coordinate payment with our business office prior to your visit. We do require payment in full at the time of service unless prior arrangements have been made.
- **All Payers** – it is the patient's responsibility to verify that we are participating providers with your health plan. In the event that we do not participate with your plan, we will file your claim as a courtesy but you will be responsible for full payment for services rendered at the time of the visit.
- We may charge you a "No Show" fee if you fail to cancel or reschedule your appointment at least 24 hours prior to your appointment date/time.
- Insufficient fees on returned checks will be $25.00.

_____ _____

Patient/Guarantor Signature Date

_____ _____

Patient Name Patient Date of Birth

UROLOGY PARTNERS

Assignment of Benefits & Notice of Privacy Practices

I authorize Urology Partners of North Texas, PLLC to submit claims and receive payment for services which may be otherwise payable to me from all sources including but not limited to my medical insurance, my employers' workers' compensation carrier or other parties for surgical/medical benefits with whom I have contracted. Such benefits will not exceed Urology Partners of North Texas, PLLC billed charges for these services. I understand that I am financially responsible to Urology Partners of North Texas, PLLC, LLC for charges not covered or paid by this assignment and will adhere to the financial policies of Urology Partners of North Texas, PLLC in the collection of these charges. I accept full responsibility for providing Urology Partners of North Texas, PLLC accurate and complete information needed for their assisting me in processing my claims for reimbursement of medical services. I authorize Urology Partners to release any information necessary to insurance carriers regarding illnesses and treatment necessary to process claims. I authorize the refund of overpaid insurance benefits where my coverage is subject to coordination of benefits.

Consent for Treatment

I hereby authorize and direct Urology Partners of North Texas, PLLC physicians together with associates and assistants of their choice to administer or perform medical treatment on the patient identified, including any additional procedures/services as they deem necessary or reasonable, including but not limited to the administration of injections, x-ray or other radiological and laboratory services. I also hereby authorize the release of medical records to referring physicians and to my insurance companies for the purpose of payment, treatment and healthcare operations. This authorization for consent to medical treatment or surgical procedures is and shall remain valid until revoked.

I have been offered or been given a copy of the Consent for Treatment and the Notice of Privacy Practices of Urology Partners of North Texas, PLLC. I have read or will read this policy. All my questions or concerns have been answered.

_____ _____

Patient/Guarantor Signature Date

_____ _____

Patient Name Patient Date of Birth