1. Assignment of Benefits and Financial Responsibility:

This document authorizes UROLOGIC SURGERY of NWI, "the practice," to bill directly and receive payment from your insurance plan for health care services rendered to you by your doctor. I hereby assign to the practice all my rights, title, and interest in any and all health insurance or other health care benefits payable to me or on my behalf by any insurance payer, including Medicare and Medicaid, private insurance and any other health plan for medical treatment rendered by the practice. I authorize the release of pertinent information necessary to process my medical claim. I also authorize direct payment to the practice of all insurance benefits payable to me for such medical treatment. In the event an insurance payer pays me directly, I agree to immediately pay such amounts to the practice. I understand that my insurance payer may pay less than the actual bill for services. I acknowledge that UROLOGIC SURGERY of NWI will work with me regarding payment, in the event I am still responsible for paying for any amounts not paid by my insurance payer, including copayments, coinsurance, and deductibles. I understand that if my insurance requires a referral, I am responsible for obtaining one prior to my appointment. I understand that **COPAYMENT IS DUE AT THE TIME OF SERVICE** (coinsurance and deductibles may also be collected at the time of service). I understand I am financially responsible for charges not covered by my insurance company. I also agree to pay any outstanding balance as well as attorney fees and costs to UROLOGIC SURGERY of NWI if this matter is referred to collection. If a Medicare beneficiary, I understand my signature requests payment to be made and authorize the release of medical information necessary to pay claims. In Medicare-assigned cases, the physician agrees to accept the charge of determination of the Medicare carrier as the full charge, and I agree I am responsible for deductible, coinsurance and non-covered services. Coinsurance and deductibles are based upon the charge determination of the Medicare carrier. **NO-SHOW FEE:** Failure to attend a scheduled appointment without providing adequate notice (within 24 hours) will result in a charge of **$50.00.** We understand that unforeseen circumstances may occur that interfere with your appointment day/time. Nevertheless, we kindly ask that you provide a 24-hour notice for any appointment changes or cancellations. I agree to UROLOGIC SURGERY of NWI storing my credit card information and charging my credit card as a "NO-SHOW FEE."

2. Patient Consent for E-Prescribing (Electronic):

I understand that UROLOGIC SURGERY of NWI may use an electronic prescription system which allows prescriptions and related information to be electronically sent between my physician and my pharmacy. I understand and agree that my physician using the electronic prescribing system may be able to see information about my medications I am already taking, including those prescribed by other physicians/providers for purposes of care coordination and care management.

3. Consent to Release Health Information:

I understand this practice uses an electronic medical record. I understand that the electronic medical record contains information about my health from my past, current and future health care practitioners. I agree that this health information may be released through the practice's electronic medical record or by other means (fax, telephone, email, and delivery or cloud-based platform): to the practice, past/current/future health care practitioners and other healthcare organizations that provide care to me, to the health insurance company named in my medical record, to any other person named in my medical record or insurance payers who pay for my treatment, and to other entities or individuals, as permitted by applicable law. I agree that these entities or individuals may use my health information to treat me, to get paid for my treatment (billing insurance companies), to do healthcare operations activities (managing my care, providing quality care, patient's safety activities and other activities necessary to operate the practice) and for other purposes, as permitted by applicable law. By signing this consent, I understand that these people will have access to all my health information in the medical record, including behavioral health and substance use disorder information (drug and alcohol treatment), my medical history, diagnosis, hospital records, clinic and doctor visit information, medications, allergies, lab test results, radiology reports, sexual and reproductive health information, communicable disease related information (sexually transmitted diseases) and HIV/AIDS related information. I understand that I may revoke this consent at any time, but my revocation will not apply to health information already released for these purposes or to a disclosure that does not require my consent. I also understand that I may request a list of the healthcare organizations that have received my substance use disorder information. This consent will not expire unless I revoke.

4. Notice of Privacy Practices:

I was provided a copy of the practice's Notice of Privacy Practices, which describes how the clinic will use and disclose my protected health information. This includes protected health information generated through use of virtual health or telemedicine services, treatment for mental health, drug and alcohol abuse, communicable diseases such as HIV/AIDS, developmental disabilities, genetic testing and other types of treatment received.

5. General Consent for Tests, Treatment and Services:

I understand the physician will determine the treatment procedures considered necessary for me and that the treatments/procedures will be directed by a physician, in accordance with applicable laws and licensure and scope of practice of medical practitioners. I understand that no guarantee or assurance has been made regarding which physicians, fellows, residents, interns, advanced practice providers will participate in my treatment. I understand that medical, nursing and other authorized healthcare providers in training may be observing and participating actively in my care under the supervision of authorized personnel. I give my consent to such observations and/or participation. I consent to examinations, blood tests (including blood tests for communicable diseases such as hepatitis and HIV/AIDS when healthcare personnel have been exposed to my blood and/or body fluids), laboratory and imaging procedures, medications, infusions, nursing care and other services or treatments given by my physician, consulting physicians, fellows, residents, interns and their associates and assistants, or given by practice personnel under the instructions, orders or directions of such physician(s), fellow(s), resident(s) or intern(s). I am aware the practice of medicine is not an exact science and understand that no guarantee has been or can be made for the results of treatments and care or examinations in the practice. I understand the practice may authorize the disposal of records in accordance with practice retention policies and applicable record retention laws.

6. Consent to Photo/Video:

I consent to the photographing, videotaping and/or video monitoring, including appropriate portions of my body, for medical and medical record documentation purposes, provided set photographs or video tapes are maintained and released in accordance with applicable laws.

7. Consent to Photograph at the Time of Registration:

I hereby give consent to the practice to take my photograph at the time of registration. I understand this photograph will be stored in the electronic medical record as my photo identification.

8. Communications:

I consent to this practice, its successors or assignees contacting me, my personal representative or an individual I designate in writing about my care for payment for my care. I understand these communications may occur in any manner, including phone calls to a cell phone or landline, voicemails on my cell phone or landline, SMS/text messages, email messages, use of automated telephone dialing systems (including automated SMS/text messages) or use of artificial or prerecorded voice messages. I understand the communications may be about any matter, including but not limited to, my medical treatment, the availability of lab or imaging results, infection information, prescriptions, consult or referral information, care management and care coordination activities, consent or authorization requests, medical record matters, insurance eligibility and coverage, scheduling or appointment reminders, on-site assistance and billing and collection matters. I understand that these communications may not be encrypted or secure, and I understand and assume the risks of transmission of health information via unsecure means. I represent that the telephone number(s) and email address(es) I provided are my contact numbers and I am permitted to receive calls/text/emails at those numbers and addresses. I agree to alert the practice whenever I stop using a particular telephone number or email address. If I incur any cost from being contacted at the telephone number(s) or email address(es) provided to the practice, including but not limited to data, roaming, text messages, additional minutes or other fees, I understand that the practice is not responsible for paying these charges. This consent also applies to any updated or additional contact information that I may provide. I understand I will be able to change my preference at any time by contacting the practice.

9. Videotaping/Recording:

I understand and agree not to photograph, videotape, audiotape, record or otherwise capture imaging or sound on any device. I also understand it is my responsibility to ensure those accompanying me comply with this requirement.

The undersigned certifies that she/he has read (or have had read to me) the foregoing, understands it, accepts its terms, and has received a copy of. I hereby agree to all terms and conditions set forth above and understand that any sections of this consent that I do not consent to I have struck through and initialed the section that does not have my consent or permission.

SIGNATURE:

Printed Name:	Date:
Patient/Guardian Signature:	Relationship: