PHOENIX UROLOGY
GENERAL CONSENT TO TREAT

1. **Consent to Treatment.** I consent to and authorize medical treatment, diagnostic procedures, tests and examinations that are ordered by the physician. This consent remains in effect for the purpose of providing continuing and future medical care and treatment. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made as to result of treatments of examinations.
2. **Authorization to Release Information.** I authorize Phoenix Urology of St Joseph to disclose and release any medical information or record of the patient to any health care professional or facility, insurance company, governmental organization or regulatory agency, or third party payor for further medical care and treatment, certification and payment of medical expenses, and discharge planning
3. **Financial Responsibility.** I promise to pay Phoenix Urology of St Joseph for all costs and charges incurred or made for or on account of the patient. I understand that I am responsible for filing and collecting insurance in a timely and accurate manner, and resolving disputed insurance or third- party payor claims. I agree that this duty and responsibility is not being assumed by the health care providers. Estimate of patient financial responsibility is due prior to or at the time of service. Payment of the balance is due when billed by Phoenix Urology. If payment is not made when due, interest will accrue as provided by law. I agree to pay any and all costs of collection, including reasonable attorney' fees and expenses. I hereby expressly consent Phoenix Urology or its billing and collection agent(s) to contact me using electronic media to include; cell phone, auto messaging, text messaging and email.
4. **Assignment of Insurance and Other Benefit.** I hereby assign to Phoenix Urology health care providers all insurance and other health care coverage benefits otherwise payable, or to become payable, to or on behalf of patient.
5. **Medicare/Medicaid/Tricare Certification, Authorization and Assignment.** If eligible, I authorize Phoenix Urology to apply for benefits from, and submit claims directly to, Medicare, Medicaid or Tricare on behalf of patient, and certify that the information given in applying for payment is correct. I hereby assign to Phoenix Urology health care providers all Medicare, Medicaid or Tricare benefits payable, or to become payable, to or on behalf of patient. I understand that if services are not covered, are not paid, or do not qualify for payment, I will be responsible for payment incurred charges, and/or, deductibles and patient's portion of qualified covered charges.

I HAVE READ AND UNDERSTAND THE ABOVE AUTHORIZATIONS AND I UNDERSTAND THAT MY SIGNATURE PERTAINS TO EACH OF THEM.

_____ _____

PATIENT SIGNATURE **DATE** **OTHER SIGNATURE**

_____ _____

DATE OF BIRTH **RELATIONSHIP TO PATIENT**

EMAIL ADDRESS: _____