

First Urology, PSC

Notice of Privacy Practices

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

If you have any questions about this Notice please contact
our Privacy Officer:

Mailing Address: 101 Hospital Blvd, Jeffersonville, IN 47130

Telephone and Fax: (812) 206-8196

Email: privacy@1sturology.com

About This Notice

We are required by law to maintain the privacy of Protected Health Information (PHI) and to give you this Notice explaining our privacy practices with regard to that information. You have certain rights – and we have certain legal obligations – regarding the privacy of your PHI, and this Notice also explains your rights and our obligations. We are required to abide by the terms of the current version of this Notice.

What is Protected Health Information (PHI)?

Protected Health Information (PHI) is information that individually identifies you and that we create or get from you or from another health care provider, a health plan, your employer, or a health care clearinghouse and that relates to (1) your past, present, or future physical or mental health or conditions, (2) the provision of health care to you, or (3) the past, present, or future payment for your health care.

How We May Use and Disclose Your PHI

We may use and disclose your PHI in the following circumstances:

For Treatment - We may use PHI to give you medical treatment or services and to manage and coordinate your medical care. For example, we may disclose PHI to doctors, nurses, technicians, or other personnel who are involved in taking care of you, including people outside our practice, such as referring or specialist physicians.

For Payment - We may use and disclose PHI so that we can bill for the treatment and services you get from us and can collect payment from you, an insurance company, or another third party. For example, we may need to give your health plan information about your treatment in order for your health plan to pay for that treatment. We also may tell your health plan about a treatment you are going to receive to find out if your plan will cover the treatment. If a bill is overdue we may need to give PHI to a collection agency to the extent necessary to help collect the bill, and we may disclose an outstanding debt to credit reporting agencies.

For Health Care Operations - We may use and disclose PHI for our health care operations. For example, we may use PHI for our general business management activities, for checking on the performance of our staff in caring for you, for our cost-management activities, for audits, or to get legal services. We may give PHI to other health care entities for their health care operations, for example, to your health insurer for its quality review purposes.

Appointment Reminders/Treatment Alternatives/Health-Related Benefits and Services - We may use and disclose PHI to contact you to remind you that you have an appointment for medical care, or to contact you to tell you about possible treatment options or alternatives or health related benefits and services that may be of interest to you.

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Minors - We may disclose the PHI of minor children to their parents or guardians unless such disclosure is otherwise prohibited by law.

Personal Representative - If you have a personal representative, such as a legal guardian (or an executor or administrator of your estate after your death), we will treat that person as if that person is you with respect to disclosures of your PHI.

As Required by Law - We will disclose PHI about you 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 PHI when necessary to prevent a serious threat to your health or safety or to the health or safety of others. But we will only disclose the information to someone who may be able to help prevent the threat.

Business Associates - We may disclose PHI to our business associates who perform functions on our behalf or provide us with services if the PHI is necessary for those functions or services. For example, we may use another company to do our billing, or to provide transcription or consulting services for us. All of our business associates are obligated, under contract with us, to protect the privacy of your PHI.

Organ and Tissue Donation - If you are an organ or tissue donor, we may use or disclose your PHI to organizations that handle organ procurement or transplantation – such as an organ donation bank – as necessary to facilitate organ or tissue donation and transplantation.

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

Workers' Compensation - We may use or disclose PHI for workers' compensation or similar programs that provide benefits for work-related injuries or illness.

Public Health Risks - We may disclose PHI for public health activities. This includes disclosures to: (1) a person subject to the jurisdiction of the Food and Drug Administration ("FDA") for purposes related to the quality, safety or effectiveness of an FDA-regulated product or activity; (2) prevent or control disease, injury or disability; (3) report births and deaths; (4) report child abuse or neglect; (5) report reactions to medications or problems with products; (6) notify people of recalls of products they may be using; (7) a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and (8) the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence and the patient agrees or we are required or authorized by law to make that disclosure.

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

Lawsuits and Disputes - If you are involved in a lawsuit or a dispute, we may disclose PHI in response to a court or administrative order. We also may disclose PHI in response to a subpoena, discovery request, or other legal process from someone else involved in the dispute, but only if efforts have been made to tell you about the request or to get an order protecting the information requested. We may also use or disclose your PHI to defend ourselves if you sue us.

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Law Enforcement - We may release PHI if asked by a law enforcement official for the following reasons: in response to a court order, subpoena, warrant, summons or similar process; to identify or locate a suspect, fugitive, material witness, or missing person; about the victim of a crime if; about a death we believe may be the result of criminal conduct; about criminal conduct on our premises; and in emergency circumstances to report a crime, the location of the crime or victims, or the identity, description, or location of the person who committed the crime.

National Security - We may release PHI to authorized federal officials for national security activities authorized by law. For example, we may disclose PHI to those officials so they may protect the President.

Coroners, Medical Examiners, and Funeral Directors - We may release PHI to a coroner, medical examiner, or funeral director so that they can carry out their duties.

Inmates - If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose PHI to the correctional institution or law enforcement official if the disclosure is 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.

Research - We may use and disclose your PHI for research purposes, but we will only do that if the research has been specially approved by an institutional review board or a privacy board that has reviewed the research proposal and has set up protocols to ensure the privacy of your PHI. Even without that special approval, we may permit researchers to look at PHI to help them prepare for research, for example, to allow them to identify patients who may be included in their research project, as long as they do not remove, or take a copy of, any PHI. We may use and disclose a limited data set that does not contain specific readily identifiable information about you for research. But we will only disclose the limited data set if we enter into a data use agreement with the recipient who must agree to (1) use the data set only for the purposes for which it was provided, (2) ensure the security of the data, and (3) not identify the information or use it to contact any individual.

Newsletters and Other Communications - We may use your PHI to communicate to you by newsletters, mailings, or other means regarding treatment options, health related information, disease management programs, wellness programs, or other community based initiatives or activities in which our practice is participating.

Medical Residents and Medical Students - Medical residents or medical students may observe or participate in your treatment or use your PHI to assist in their training. You have the right to refuse to be examined, observed, or treated by medical residents or medical students.

Uses and Disclosures That Require Us to Give You an Opportunity to Object and Opt Out

Individuals Involved in Your Care or Payment for Your Care - We may disclose PHI to a person who is involved in your medical care or helps pay for your care, such as a family member or friend, to the extent it is relevant to that person's involvement in your care or payment related to your care. We will provide you with an opportunity to object to and opt out of such a disclosure whenever we practicably can do so.

Disaster Relief - We may disclose your PHI to disaster relief organizations that seek your PHI 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 practicably can do so.

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Patient Portal - Upon your request or consent, we will make your medical chart available to you via our patient portal at mymedicallocker.com. This site is maintained and supported by our EMR vendor. This portal will allow you to view your clinical summary from your office visits as well as additional information regarding your care. If you have questions or issues with using your portal account, please contact First Urology IT at 812.282.3899, ext. 5555 or portal@1sturology.com.

Your Written Authorization is required for Other Uses and Disclosures

Uses and disclosures for marketing purposes and disclosures that constitute a sale of PHI can only be made with your written authorization. Other uses and disclosures of PHI 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 PHI under the authorization. Disclosures that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

Special Protections for HIV, Alcohol and Substance Abuse, Mental Health, and Genetic Information

Special privacy protections apply to HIV-related information, alcohol and substance abuse, mental health, and genetic information. Some parts of this general Notice of Privacy Practices may not apply to these kinds of PHI. Please check with our Privacy Officer for information about the special protections that do apply. For example, if we give you a test to determine if you have been exposed to HIV, we will not disclose the fact that you have taken the test to anyone without your written consent unless otherwise required by law.

Your Rights Regarding Your PHI

You have the following rights, subject to certain limitations, regarding your PHI:

Right to Inspect and Copy - You have the right to inspect and/or receive a copy of PHI that may be used to make decisions about your care or payment for your care. But you do not have a right to inspect or copy psychotherapy notes. We may charge you a 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 or 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 PHI is maintained in one or more designated record sets electronically (for example 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 may charge you a reasonable, cost-based fee for the labor associated with copying or transmitting the electronic PHI. If you chose to have your PHI transmitted electronically, you will need to provide a written request to this office listing the contact information of the individual or entity who should receive your electronic PHI.

Right to Receive Notice of a Breach - We are required to notify you by first class mail or by e-mail (if you have indicated a preference to receive information by e-mail), of any breach of your Unsecured PHI.

Right to Request Amendments - If you feel that PHI 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 us. A request for amendment must be made in writing to the Privacy Officer at the address provided at the beginning of this Notice and it must tell us the reason for your request. We may deny your request if it is not in writing or does not include a reason to support the

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request. In addition, we may deny your request if you ask us to amend information that (1) was not created by us, (2) is not part of the medical information kept by or for us, (3) is not information that you would be permitted to inspect and copy, or (2) is accurate and complete. If we deny your request, you may submit a written statement of disagreement of reasonable length. Your statement of disagreement will be included in your medical record, but we may also include a rebuttal statement.

Right to an Accounting of Disclosures - You have the right to ask for an "accounting of disclosures," which is a list of the disclosures we made of your PHI. We are not required to list certain disclosures, including (1) disclosures made for treatment, payment, and health care operations purposes, (2) disclosures made with your authorization, (3) disclosures made to create a limited data set, and (4) disclosures made directly to you. You must submit your request in writing to our Privacy Officer. Your request must state a time period which may not be longer than 6 years before your request. Your request should indicate in what form you would like the accounting (for example, on paper or by e-mail). The first accounting of disclosures you request within any 12-month period will be free. For additional requests within the same period, we may charge you for the reasonable costs of providing the accounting. We will tell you what the costs are, and you may choose to withdraw or modify your request before the costs are incurred.

Right to Request Restrictions - You have the right to request a restriction or limitation on the PHI we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the PHI we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. We are not required to agree to your request. If we agree, we will comply with your request unless we terminate our agreement or the information is needed to provide you with emergency treatment.

Right to Restrict Certain Disclosures to Your Health Plan - You have the right to restrict certain disclosures of PHI to a health plan if the disclosure is for payment or health care operations and pertains to a health care item or service for which you have paid out of pocket in full. We will honor this request unless we are otherwise required by law to disclose this information. This request must be made at the time of service.

Right to Request Confidential Communications - You have the right to request that we communicate with you only in certain ways to preserve your privacy. For example, you may request that we contact you by mail at a special address or call you only at your work number. You must make any such request in writing and you must specify how or where we are to contact you. We will accommodate all reasonable requests. We will not ask you the reason for your request.

Right to a Paper Copy of This Notice - You have the right to a paper copy of this Notice, even if you have agreed to receive this Notice electronically. You may request a copy of this Notice at any time. You can get a copy of this Notice at our website: <http://www.1sturology.com>.

How to Exercise Your Rights

To exercise your rights described in this Notice, send your request, in writing, to our Privacy Officer at the address listed at the beginning of this Notice. We may ask you to fill out a form that we will supply. To get a paper copy of this Notice, contact our Privacy Officer by phone or mail.

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Changes to This Notice

The effective date of the Notice is stated at the beginning. We reserve the right to change this Notice. We reserve the right to make the changed Notice effective for PHI we already have as well as for any PHI we create or receive in the future. A copy of our current Notice is posted in our office and on our website.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. To file a complaint with us, contact our Privacy Officer at the address listed at the beginning of this Notice. All complaints must be made in writing and should be submitted within 180 days of when you knew or should have known of the suspected violation. There will be no retaliation against you for filing a complaint.

First Urology, PSC

Notice of Financial Responsibility

Thank you for choosing First Urology, PSC for your health care needs. The patient financial policy has been developed to assist in answering questions regarding patient and insurance responsibility for services rendered. Your understanding of and compliance with our patient financial policy is important.

Please read the policy below and if you have any questions call the Insurance department at (812) 206-8188.

Proof of Insurance

All patients must complete our patient information form before seeing the physician. It is your responsibility to ensure that we have your correct information and an up-to-date copy of your insurance card.

Updated Change of Information & Coverage

We will ask you to update this whenever you have a change in address, employment, insurance, etc. However, it is your responsibility to make us aware of these changes in a timely manner. If you fail to provide us with the correct updated information, you will be responsible for the entire cost of the services rendered and immediate payment will be expected.

Co-payments, Deductibles & Co-insurance

All co-payments, deductibles & co-insurance must be paid at the time of service. Payment is part of your contract agreement with your insurance plan. Our failure to collect payment may be a violation of billing compliance.

Non-covered Services

Please be aware that some or perhaps all of the services you receive may not be covered by your insurance plan. You will be responsible for any non-covered services.

Referrals

Some insurance plans require a referral from a primary care physician to obtain services of a specialist. These health plans will not pay for services rendered without a referral. It is *your* responsibility to obtain a referral prior to treatment.

Authorizations

Obtaining a prior authorization for services is not a guarantee of payment of benefits. A prior authorization means that the information given at that time meets the medical necessity for the services but is not a guarantee of payment. Your insurance plan will confirm to you that even though the services may be authorized, the services may not be covered under your plan and a decision for payment will not be rendered until the claim is submitted.

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Claims Submission

We will submit your claims and assist you in any way we can to help get your claims paid. Your insurance plan may request information directly from you. Your failure to timely comply with your insurance plan's request may result in your claim denying and if so, will result in our seeking full reimbursement from you for services rendered. Your insurance benefit is a contract between you and your insurance plan.

Fraud laws prohibit us from changing your procedure and/or diagnosis codes "just to get your claim paid." In addition to charges related to your office visit, there may be separate charges for professional services rendered by other, non-First Urology, PSC providers. For example, if your urologist orders additional diagnostic imaging or laboratory testing, there may be separate charges from the organizations rendering those services.

Surgical Fees

We will contact your insurance company to determine insurance benefits prior to any scheduled surgery. Our business office will contact you prior to your surgery if you have any out-of-pocket expenses (deductibles, coinsurance, etc.) that may be your responsibility. While we make every effort to get up to date out-of-pocket costs from your insurance company, the amount quoted is subject to change in accordance with your insurance benefits. Payment of these fees are expected prior to time of service, unless other arrangements have been made with the business office.

Non-payment

Once insurance has processed your claim and there remains a patient balance due, you will receive a statement from our vendor, Millennia Patient Services (MPS). MPS will assist you with establishing a payment plan, if you are unable to pay in full. Please be aware that if a balance remains unpaid, we reserve the right to turn your account over to a collection agency. Questions for MPS can be directed to (866) 270-8965.

Payment Methods

We accept cash, personal check, money order, cashier's check, MasterCard, Visa and Discover as payment for services rendered.

Returned Checks

A returned check fee of \$30 will be added to your account for every check returned.

No Show Policy

If you are unable to keep your appointment, please let us know as soon as possible so we can offer that appointment time to another patient. We reserve the right to charge a fee for appointments not cancelled at least 24 hours in advance.

First Urology, PSC
Patient Information Form

(Please Print)

Patient Information

Full Name _____ Account #: _____

Language _____ Race ☐ American Indian or Alaska Native ☐ Asian

Ethnicity ☐ Not Hispanic or Latino ☐ Black or African American ☐ White

☐ Hispanic or Latino ☐ Native Hawaiian or Other Pacific Islander

Date of Birth ____/____/____ Age ____ Sex: ☐ Male ☐ Female Social Security # _____

Home Address _____
Street City State Zip

Preferred Method of Contact ☐ Home Phone ☐ Mobile Phone ☐ Email ☐ Letter

Home Phone (____) _____ Work Phone (____) _____ Mobile Phone (____) _____

Home Email _____ Fax # (____) _____

☐ Please create an account for me at MyMedicalLocker.com (See attached info)

Employer _____

Spouse's Full Name _____ Date of Birth ____/____/____

Spouse's Social Security # _____ Spouse's Work Phone (____) _____

Spouse's Employer _____

Primary Care Physician _____ Office # _____

Responsible Party

If you are providing the information above for a patient under the age of 18 years old, please complete this section.

Child's Father's Name _____ SSN _____ DOB ____/____/____

Father's Address (if different from above) _____
Street City State Zip

Father's Employer _____ Father's Work Phone (____) _____

Child's Mother's Name _____ SSN _____ DOB ____/____/____

Mother's Address (if different from above) _____
Street City State Zip

Mother's Employer _____ Mother's Work Phone (____) _____

Please Note: It is the policy of this office that the parent accompanying the child for treatment will be held responsible for all bills. We cannot bill the other parent.

Patient Name _____

Account #: _____

Emergency Information

Name _____ Home Phone (____) _____ Work Phone (____) _____

Privacy

Receipt of Notice of Privacy Practices Written Acknowledgement (Please Initial)

_____ I was provided a Notice of Privacy Practices by First Urology, PSC to read and keep as my own.

_____ I declined a copy that was offered to me, but I am aware of my rights.

_____ I authorize the release of any medical or incidental information necessary to provide continuity of my (the patient's) medical care and to process my (the patient's) medical insurance.

_____ I agree to receive additional information regarding opportunities in advancing my medical care.

My Protected Health Information may be disclosed to: ☐ Self Only

☐ Spouse/Partner: _____ ☐ Parent/Guardian: _____ ☐ Other: _____

I give permission for First Urology, PSC to leave a message regarding test results on my:

☐ Home Answering Machine/Voice Mail ☐ Mobile Voice Mail ☐ Work Voice Mail

Financial

Financial Policy (Please Initial)

_____ I acknowledge that I was provided a Notice of Financial Policy by First Urology, PSC to read and keep as my own. I understand that I am financially responsible for any balance.

_____ For any services rendered, I authorize the assignment of benefits (payments) from my insurance to come directly to First Urology, PSC.

Financial Interest Disclosure (Please Initial)

_____ One or more First Urology physician(s) is/are investors in Physicians' Medical Center, Radiotherapy Clinics of Kentuckiana, Owensboro Lithotripsy and Louisville Lithotripsy. You may choose to be referred to another entity. First Urology physicians are proud of the quality of care these entities provide for our patients.

Insurance

Do you have medical insurance?

☐ **Yes** - Please provide copy of card at time of service. Co-payment is required at time of service.

☐ **No** - Payment is expected at time of service. We accept Cash, Check, Visa, or MasterCard.

Signed _____ Date ____/____/____

First Urology, PSC
Patient Medical History

(Please Print)

Patient Name _____ DOB ____/____/____ Date ____/____/____ Account # _____

Doctor for Today's Visit _____

History of Present Illness

Describe the urologic problems you are experiencing and why you are here.

Review of Systems

Have you experienced any of the below symptoms in the past 2 weeks or since your last visit?

Constitutional Symptoms

Fever ☐ Yes ☐ No

Cardiovascular

Chest Pain ☐ Yes ☐ No

Hematologic

Easy Bruising ☐ Yes ☐ No

Genitourinary

Leak Urine or Wet Yourself (Incontinence) ☐ Yes ☐ No

Respiratory

Shortness of Breath ☐ Yes ☐ No

Gastrointestinal

Constipation ☐ Yes ☐ No

Neurological

Decreased Sensation ☐ Yes ☐ No

Ear/ Nose/ Throat/ Mouth

Hearing Loss ☐ Yes ☐ No

Musculoskeletal

New Bone Pain ☐ Yes ☐ No

Immunologic

Latex Allergy ☐ Yes ☐ No

Vitals

To be filled in by office staff.

Height _____ft _____ins Weight _____lbs _____ozs Blood Pressure _____/_____ mmHG Pulse _____ BPM Temperature _____°

Allergies

List all of the allergies that you have, including latex.

☐ No known drug allergies. Allergic to _____

Medications

List all of the medications that you currently take.

☐ Not currently taking medications.

Medication and Dose

- | | |
|----------|----------|
| 1. _____ | 2. _____ |
| 3. _____ | 4. _____ |
| 5. _____ | 6. _____ |
| 7. _____ | 8. _____ |

Social History

Please answer the below questions to the best of your ability.

Tobacco Use

<input type="checkbox"/> Never smoked	<input type="checkbox"/> Every day/ Occasional smoker	<input type="checkbox"/> Former smoker
	Packs Per Day _____	Packs Per Day _____
	Years Smoked _____	Years Smoked _____
		Date Quit _____

Recreational Drug Use

☐ Yes Type _____
☐ No

Alcohol Use

<input type="checkbox"/> Never drinks	<input type="checkbox"/> Every day/Occasional drinker	<input type="checkbox"/> Former drinker
	Type _____	Type _____
	Drinks per week _____	Drinks per week _____
		Date Quit _____

Sexually Active

☐ Yes
☐ No

Past Medical History

Answer each item to indicate your current and past medical conditions. Please explain all yes answers.

Anemia	<input type="checkbox"/> Yes	Blood in Urine/Stool	<input type="checkbox"/> Yes	Gastrointestinal	<input type="checkbox"/> Yes	Kidney Stones	<input type="checkbox"/> Yes
Asthma, Emphysema	<input type="checkbox"/> Yes	Cancer	<input type="checkbox"/> Yes	Heart Disease	<input type="checkbox"/> Yes	Pregnancies	<input type="checkbox"/> Yes
Bladder/ Kidney Infect.	<input type="checkbox"/> Yes	(Type:_____)	<input type="checkbox"/> Yes	Hepatitis	<input type="checkbox"/> Yes	Prostate Problems	<input type="checkbox"/> Yes
Bleeding Disorder	<input type="checkbox"/> Yes	Diabetes	<input type="checkbox"/> Yes	High Blood Pressure	<input type="checkbox"/> Yes	Stroke	<input type="checkbox"/> Yes
Blood Clots	<input type="checkbox"/> Yes	Erection Problems	<input type="checkbox"/> Yes	Incontinence	<input type="checkbox"/> Yes	Urination Problems	<input type="checkbox"/> Yes

Surgical and Hospital History

List all surgeries and/or hospitalizations that you have had and the year in which they occurred.

☐ No past surgeries ☐ No past hospitalizations

Surgery or Hospital Details**Date****Surgery or Hospital Details****Date**

1. _____

____/____/____

2. _____

____/____/____

3. _____

____/____/____

4. _____

____/____/____

5. _____

____/____/____

6. _____

____/____/____

7. _____

____/____/____

8. _____

____/____/____

9. _____

____/____/____

10. _____

____/____/____

Family History

List history of cancer, stone disease, heart disease, diabetes or other serious health issues.

Family Member**Living Status****Medical Condition/Cause and Year/Age of Death**☐ Alive☐ Deceased☐ Alive☐ Deceased☐ Alive☐ Deceased☐ Alive☐ Deceased**Other Clinicians**

List any other clinicians that you are currently seeing for medical attention along with their contact information.

Primary Care Physician

Medical Oncologist

Radiation Oncologist

Ob/Gyn

Dentist

Other

Other

First Urology, PSC Parental Consent

(Please Print)

Patient Name _____

Account #: _____

We realize that Parents or Legal Guardians may not always be able to personally bring their child to our office. However, state law dictates that a patient under the age of 18 cannot be treated without a parent or Legal Guardian present. If a Parent or Legal Guardian cannot be present, then anyone authorized below can accompany the child and give consent for treatment. This form must be completed by a Parent or Legal Guardian. Please inform your authorized person(s) that our staff will ask them for photo identification.

I, _____, the Parent or Legal Guardian of _____,
give consent for the following people to have my child treated by First Urology, PSC and its staff:

Authorized Person(s)

Relationship to Patient

Signed _____ Date ____/____/____

(Parent or Legal Guardian only)