FAYETTEVILLE UROLOGY ASSOCIATES
1786 METROMEDICAL DRIVE
FAYETTEVILLE, NC 28304

WAIVER FORM

For consultation, items, services, and/or surgical procedures:

Health insurance providers including Medicare, Medicaid, and private insurance carriers may not pay for all of your health care costs. The fact that some insurance carriers do not pay for particular items, services, or surgery does not mean that you should not proceed with the recommendations of your doctor. Some procedures may be considered "cosmetic" or "not medically necessary" even if your doctor recommends the procedure to improve symptoms.

We are happy to file charges to your insurance company; however, there is no contractual obligation for our office to do so. Because we do not participate with all insurance companies, you will be responsible for any outstanding balance on your account once your insurance has processed your claim. It is the patient's responsibility to monitor insurance payments and if any amounts are unpaid which the patient feels should have been paid, it is the patient's responsibility to resolve the matter directly with the insurer. If any amount is turned over by the physician's office to a collection agency or an attorney for collection, the patient will be responsible for all collection charges, including reasonable attorney's fees and court costs.

The purpose of this form is to assure that you are making an informed choice about whether you want to receive these items, services, or surgery knowing that you might be responsible for paying for them.

Please check one of the following:

_____**YES,** proceed with consultation, items, services and/or surgery. Claims will be submitted to the insurance carrier(s). I, the patient will be responsible for payment in the event that the insurance carrier(s) do not pay for the consultation, items, services, and/or surgery I receive.

____**NO**, I do NOT want to proceed with the consultation, items, services and/or surgery.

Signature of patient/Legal Guardian Name (Please Print)

Date

Deemed Consent for Designated Blood Borne Pathogens
Consent to Medical Care, and Release of Protected Healthcare Information:

North Carolina law requires Health Care Providers to notify you that Hepatitis B and C or HIV (Aids) Virus testing on a sample of your blood may be done if a health care worker is exposed to your blood or body fluids. This following notice is to advise you that this is in effect at this facility:
As a Health Care Provider, whenever any health care worker associated with or working for Fayetteville Urology Associates is directly exposed to body fluids of a patient in a manner which, according to the guidelines of the Center for Disease Control, may transmit human immunodeficiency virus or Hepatitis B and C, Fayetteville Urology Associates will proceed to test the patient through his or her physician as well as the health care worker(s) who was/were exposed.

When a person is tested, we automatically test for Hepatitis B and C for the safety of all concerned. Fayetteville Urology Associates policy protects you as a patient, should you be exposed.

Consent:
I voluntarily consent to medical care at Fayetteville Urology Associates, which may include examinations, tests, photographs and treatments by doctors and the staff. No promises have been made to me as to the results of treatment or examinations.

I hereby authorize Fayetteville Urology Associates and its staff to use and/or disclose my protected health information for the purpose of treatment, payment, and health care operations (TPO). I understand health care operations may include, among others, uses or disclosures relative to quality review, utilization review, medical necessity, or legal review. Protected health information may include medical records, insurance and payment information, and other information used, in whole or in part, to make decisions about me.

With my consent, Fayetteville Urology Associates may call or mail to my home, or other designated locations, and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others. Fayetteville Urology Associates Notice of Privacy Practices provides me with more information about how the practice and its staff may use and disclose my protected health information for these purposes.

I certify that the information I have reported in regards to my insurance coverage is correct.

I hereby authorize the release of pertinent information to my insurance company or HCFA and any other doctors involved with my case.

I authorize my insurance benefits to be paid directly to the physician, realizing that I am financially responsible to pay for any non-covered services. If my account becomes assigned to a collection agency, I agree to pay all costs of collections, including agency and attorney fees.

I acknowledge that I have received or been offered a copy of Fayetteville Urology Associates Notice of Privacy Practices.

BY SIGNING BELOW, I AGREE WITH THE FOREGOING STATEMENTS

_____Patient unable to sign or acknowledge

Signed_____**Date**_____

Relationship to patient

___ Patient ____ Spouse ____ Parent ____ Child _____ Sibling _____ Other