Permissions, Consents, and Responsibilities

Patient Name: _____

Consent to Treat: I hereby authorize and consent to the performance of examinations, diagnostic procedures, and treatments which my physician and I agree are necessary. I understand that no guarantee has been made as to the results of the care, treatment and/or medications given to me. This consent shall remain in effect until I choose to revoke it in writing.

Release of Information and Assignment of Benefits: I understand that I am responsible for any fees for service rendered for myself and/or for my children (if applicable). I hereby authorize Arif Agha, MD/Oak Brook Urology to release any medical information to my insurance carrier concerning all conditions including those that may reference drug abuse, alcohol abuse or mental illness in order to process any claims on my behalf. I hereby assign to Arif Agha, MD/Oak Brook Urology payments made by my insurance carrier.

Authorization to Discuss My Account: I hereby authorize the staff of Arif Agha, MD/Oak Brook Urology to discuss appointment information, test results and financial information with the following named person:

_____

_____

Commitment to Your Care: I understand that in order to have an effective doctor-patient relationship it is my responsibility to be compliant with the physician's treatment recommendations and office policies. I understand that I may terminate this relationship at any time and request my records to transfer my care to another urologist. I further understand that the Oak Brook Urology' physicians may terminate the doctor-patient relationship at any time by giving 30-day written notice.

Privacy Notice: I hereby give my consent to Arif Agha, MD/Oak Brook Urology to use or disclose, for the purpose of carrying out treatment, payment or health care operations, all information contained in my patient record. I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so, to the physician. I also understand that I will not be able to revoke this consent in cases where the physician has already relied on it to use or disclose my health information. I acknowledge that I have received the Arif Agha, MD/Oak Brook Urology Notice ofPrivacy Practices brochure or have received it on a prior visit.

X _____

Signature of Patient or Responsible Party

_____ Name

_____ Date

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