OCU PATIENT CONSENT

Patient Name: ________________________ Social Security No.: ________________________

Date of Birth: ________________________ Phone Number: ________________________

Name of Spouse: ________________________ Spouse SS Number: ________________________

Emergency Contact: ________________________ Phone Number: ________________________

I request that payment of authorized insurance benefits for any services provided be made to Oakland County Urologists, P.C. I authorize release of any medical and insurance information to any of my physicians, insurance companies, or ________________________ (individual selected). The information may be communicated by phone, fax and/or mail.

I understand and agree to pay for co-payments, deductibles, or amounts denied and not covered by insurance. If a member of a HMO, I understand I am responsible for obtaining a referral for my care, and agree to pay for any services for which I do not receive a referral. I authorize Oakland County Urologists, P.C. to request medical records from my other physicians and I authorize my other physicians to release my medical records to Dr. ________________________.
A copy of this authorization shall serve as the original. As parent or guardian, I, ________________________ agree to the above. I guarantee payment for all services rendered and authorize Dr. ________________________ to examine, test, and render treatment to the above patient.

________________________ ________________________

Patient/Parent/Guardian Signature Date:

OAKLAND COUNTY UROLOGISTS, P.C.

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