UROLOGY, P.C.
5500 Pine Lake Road Lincoln, Nebraska 68516 (402) 489-8888 Fax (402) 421-1945

AUTHORIZATION

I, _____, certify that I am the parent/legal guardian of _____ DOB _____, and that I am authorized to provide informed consent for any medical treatment. I hereby give my express consent for Urology P.C. ("Clinic") providers and staff to perform the following procedures:

_____ Diagnostic procedures such as physician examination, radiology and laboratory (including, but not limited to x-ray, CT scan, urinalysis, cystoscopy);

_____ Medical and Surgical Treatment as deemed necessary by the Clinic healthcare providers;

_____ Ongoing treatments or therapy

_____I understand the nature of the treatment or procedures, and I acknowledge that no guarantees have been made to me as to the results of treatment or examination performed at the Clinic.

_____ I authorize the patient to attend appointment alone.

_____ I will also authorize the following people to accompany to their appointments and to consent for treatment in my absence as needed: _____.

_____Furthermore, I acknowledge that if I am also the individual financially responsible for any and all medical examinations and treatments provided to the patient at the Clinic. I hereby assign and authorize payment directly to the Clinic and those provider(s) providing care of any and all third party payor benefits otherwise payable to me. I hereby agree that the Clinic and the provider(s) may issue a receipt for any such payment and that this receipt shall be a conclusive acknowledgment by me that I have received insurance benefits from the insurance company(ies) in the sum specified in such receipt and agree that such payment shall discharge the insurance company(ies) of any and all obligations under the policy(ies) to the extent of such payment for that purpose. I expressly authorize the clinic and the provider(s) to furnish the insurance company(ies) with any information desired concerning said medical care and treatment. I understand that I am financially responsible to the Clinic and the provider(s) for charges not covered by this assignment and further agree to guarantee prompt payment in full of any balance due.

A photocopy of this document shall be considered as valid as the original. This authorization is valid for one year from date of signature.

Dated this ___ day of _____, _____

_____ _____
Signature of Parent or Legal Guardian Date

_____ _____
Witness Signature Witness (Print)