UROLOGY CENTER PATIENT RESPONSIBILTY FORM (2017)

PLEASE INITIAL BESIDES EACH SECTION TO ACKNOWLEDGE:

_____ 1. I acknowledge that my physician is my partner in health. As an adult, it is my responsibility to keep track of my medical conditions, medications, and all other physicians that are involved in my medical care. It is my responsibility to inform every physician or other health care provider that I encounter about any changes in my medications, medication dosages, any medical conditions or any evaluations in progress.

_____ 2. I acknowledge that to help protect me from identity theft – this medical office participates in the federal regulation program titled the "Red Flags Rule." As a result, I acknowledge that I will be REQUIRED to present my photo ID and ALL insurance cards at EVERY office visit. Copies of these will be part of my medical record.

_____ 3. Test results are usually reviewed in the office at a follow-up appointment or by phone call. I acknowledge that if I am **NOT** notified of any test results obtained or referred by this office, then I will contact the office to make arrangements to receive the results. I will not assume that not receiving results means everything is normal or OK.

_____ 4. I acknowledge that if I fail to keep an advised follow-up appointment to go over test results, monitor treatment, or evaluate symptoms, then I am responsible if this results in harm to myself, delay in diagnosis, or failure to treat or cure.

_____ 5. I acknowledge that I am responsible for scheduling my own appointments. As a courtesy -- the physician's office will attempt to contact me one or two days prior to remind me of the appointment, however I may not receive this message for various reasons.

_____ 6. I acknowledge the importance of making sure the physician's office has my current address and all phone number contacts. If my information on file is not current, then I acknowledge that my physician's office will not be able to notify me about abnormal test results, medication recalls, changes in appointment or surgery scheduling, etc.

_____ 7. I acknowledge that I am responsible to know the insurance benefits provided by my insurance carrier(s). Any questions I have regarding my insurance benefits will be directed to my Insurance carrier or Human Resources department by my guarantor or myself.

NAME **SIGNATURE** **DATE**