

Urodocs
Modern Compassionate Urology

AUTHORIZATION AND CONSENT TO TREAT:

I request, consent and authorize Dr Levin and staff to evaluate and treat me as indicated.

I understand that certain circumstances may preclude a written consent and will be asked to give verbal consent for those treatments and in office procedures as deemed necessary. My verbal consent to treat will be considered as equal to a written informed consent. I also agree that under certain circumstances Dr Levin and / or staff may be required to perform emergency services on my behalf and I agree, including the calling of 911 to provide emergency ambulance services to the local hospital.

I understand that Dr Levin is providing me with care to the best of his ability and will be explaining the risks benefits indications and options, as well as morbidity and mortality as indicated. I agree to ask for clarification if at any time any of this is unclear.

Responsibility to follow up: I/we understand it the patient's sole responsibility to make sure to follow up on any tests, biopsies, imaging, results, and/or recommendations. Dr Levin and Urodocs cannot be held liable for any failure to follow up on results, keep appointments, even if rescheduled or delayed, for any reason.

CONSENT TO OBTAIN RECORDS – Recognizing the importance of accurate follow up in maintaining quality care, I hereby authorize Dr. Richard D. Levin to obtain medical information pertinent to my medical condition including, but not limited to, the diagnosis, treatment and care offered or rendered to me, as well as my records. This information will be treated as part of the medical record of Richard D. Levin, MD, FACS. This consent remains in effect until revoked by me. Dr. Levin will not be able to obtain any records from his prior practice.

NOTICE TO PATIENTS

"Under Florida law, physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. However, certain part-time physicians who meet state requirements are exempt from the financial responsibility law. Your doctor meets these requirements and may decide not to carry medical malpractice insurance. This notice is provided pursuant to Florida law."

BINDING ARBITRATION

In the event a dispute shall arise between the parties and this medical practice (Urodocs, Dr Levin and staff) it is hereby agreed that the dispute shall be referred for arbitration in accordance with the applicable United States Arbitration and Mediation Rules of Arbitration. The arbitrator's decision shall be final and legally binding and judgment may be entered thereon.

Each party shall be responsible for its share of the arbitration fees in accordance with the applicable Rules of Arbitration. In the event a party fails to proceed with arbitration, unsuccessfully challenges the arbitrator's award, or fails to comply with the arbitrator's award, the other party is entitled to costs of suit, including a reasonable attorney's fee for having to compel arbitration or defend or enforce the award

PRIVACY PRACTICES /OFFICE PRACTICES ACKNOWLEDGEMENT /AUTHORIZATION FOR RELEASE OF INFORMATION - I understand this information will only be furnished: (1) to my insurer(s) to which my medical bills have been assigned for payment; (2) as required by law; (3) upon my written authorization on a form acceptable to Dr. Richard D. Levin's office. Unless otherwise stated, I understand that Dr. Levin and staff may need to communicate my health information with other physicians and member of my medical team to facilitate my care. I understand that my medical information will not be released to any other than my medical team and those named without my express written or verbal permission. I also understand that with my written permission, my entire record including my HIV status can be released to the healthcare provider as specified I my written request. Any revocation of this release must be submitted in writing to Richard D. Levin, MD, FACS. I also authorize Dr. Levin to release my medical information to other health care providers as deemed necessary for my care.

For the purpose of this release, "medical information" shall mean copies of all medical records, tests, x-rays, reports and/or other material in the possession of Richard D. Levin, MD, FACS 'office relating to my medical condition and proposed or actual treatment. I UNDERSTAND THAT BY SIGNING THIS CONSENT, I AM ALSO AUTHORIZING RELEASE OF ANY INFORMATION CONTAINED WITHIN THE MEDICAL RECORD WHICH MAY BE RELATED TO AIDS AND/OR HIV ANTIBODY OR ANTIGEN TESTING.

By signing this Consent to Release Medical Information, I agree not to hold liable Dr. Richard D. Levin, the office staff, agents or employees, (or any unfavorable outcomes as the result of releasing this information). I REALIZE THAT RELEASE OF MY MEDICAL INFORMATION MAY BE NECESSARY BEFORE MY INSURER WILL COVER THE COST OF MY MEDICAL TREATMENT, AND THAT BY FAILING TO AUTHORIZE THE RELEASE OF THIS INFORMATION, I MAY BE REQUIRED TO PAY THE ENTIRE BILL, to facilitate my medical care.

Language:

I understand that Dr. Levin and staff may speak English or other languages with me, however it is my own responsibility to be certain I understand my care. If unable to understand I will provide for my own family or other to help with translation.

Messaging Consent: I consent to automated massaging and being contacted by Cell Phone Text messaging and or EMAIL is deemed Necessary by Urodocs and Staff.

Audio/Video Consent: I consent to Use of Audio/Video recording of any part of my evaluation and management, in accordance with appropriate privacy practices.

I have received the **Notice of Privacy Practices** and I have been provided an opportunity to review it and agree with the above and wish Dr Levin and staff to provide for my care. By signing this page I attest that all the information I am providing to the office of Dr. Levin is true and accurate.

(Signature)

_____/_____/_____
(Date)