GENERAL CONSENT AND AUTHORIZATIONS

GENERAL CONSENT FOR TREATMENT

I authorize the physicians of Cumberland County Hospital System, Inc., d/b/a Cape Fear Valley Health System (CFVHS), or authorize agents and employees of CFVHS, to administer medical treatment or diagnostic procedures and do any acts which they deem in their judgment necessary or proper for treatment. I consent to additional and different treatment or procedures as may be necessary. I acknowledge that no guarantee has been made to me concerning the results of any such treatment or procedures. This consent shall be effective from the date it is executed until the date I terminate it by communicating my revocation to my physician. By signing below, I am indicating that I am fully informed as to the contents of this consent and I have read it and it has been explained to me.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I hereby authorize CFVHS to release all information necessary to secure the payment of benefits for medical services. I authorize this signature on all insurance submission whether manual or electronic. I specifically authorize the physicians of CVFHS to disclose information in my medical records, including copies to:

- Government agencies or programs;
- Managed care organizations and /or insurance companies;
- Utilization review organization contracted by my employer, insurance company or government agency or programs;
- Physicians or health care institutions responsible for further care or follow up treatment to serve the goal of continuation of my care.

THIS AUTHORIZATION INCLUDES THE RELEASE OF MEDICAL RECORES AND/OR INFORMATION CONCERNING DRUG ABUSE RELATED CONDITIONS, ALCOHOLISM, PSYCHOLOGICAL CONDITIONS, PSCHIATRIC CONDITIONS, AND/OR COMMUNICABLE DISEASES INCLUDING ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS), OR TEST FOR INFECTION WITH HUMAN IMMUNODEFICIENCY VIRUS (HIV), IF PRESENT.

I understand this authorization may be revoked by me at any time except to the extent action has been taken prior to revocation.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize payment directly to CFVHS of all benefits, if any, otherwise payable to me including major medical insurance for services rendered.

FINANCIAL AGREEMENT

The undersigned agree jointly and severally, whether they sign as guarantor or as patient, that in consideration of the services rendered to the patient, they do hereby guarantee payments to CFVHS. I (We) acknowledge that payment is at the time of treatment unless other arrangements are made. I (We) accept full financial responsibility for all charges not covered by insurance. I understand that I am financially responsible for all charges regardless of insurance payment.

_____	_____	_____
Patient or Legal Representative Signature	Relationship to Patient	Date
_____	_____	
Witness	Date	
_____	_____	
Translator/Interpreter signature or print name, ID number and check if ATT/Language Line No Translator/Interpreter needed	Date	

CAPE FEAR VALLEY
UROLOGY

Patient Name _____

DOB _____

Chart # _____