Thomas X. Minor, M.D. & Nadeem Rahman, M.D.

Financial Liability

Patient Name: _____

ACCT # _____

DOB: _____

INSURANCE / BENEFITS / CONSENT

I hereby give consent to release or obtain information to/from physicians and other medical personnel, as may be required in the rendering of treatment. I understand that I am financially responsible to the above named office for the services rendered. In the event of collection action, I shall be responsible for any legal fees incurred. This authorization expires one (1) year from the date of signature.

California Urology makes a good faith attempt to determine benefit levels & estimate any charges you may incur. It is ultimately your responsibility to understand your level of coverage from your insurance company and whatever financial responsibility you will ultimately have. It is your responsibility to supply us with appropriate billing information. This includes current insurance identification as well as the billing address and anything else required by your insurance carrier for payment of claims. It is your responsibility to be sure that your referral and authorization arrive prior to your visit. If you consent to receive medical services that are considered a "non-covered benefit" by your insurance, you will be held financially responsible for these charges.

Patient Signature: _____

Parent or guardian (if patient is under 18 years old) **_____**

For office use only, collected by: _____

Note: California Urology is a part of Community Foundation Medical Group (CFMG). All billing statements regarding charges incurred by any services provided by our physicians will come from and be processed by CFMG.

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