

**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 Nebraska Urology ("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 be available during the visit, either in person or by telephone, for consultation if the healthcare provider deems it appropriate (to discuss risks, benefits, and alternatives to surgical treatment, give verbal consent for surgical treatment, etc.).

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

\_\_\_\_\_ Furthermore, 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 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 will assign and authorize payment 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)