BUCKHEAD
UROGYNECOLOGY

Patient Intake

CONSENT TO TREAT

I understand the completeness and accuracy of my medical and insurance information is critical to receiving safe and effective medical care and to allow for billing for these services. I understand that it is my responsibility to inform Buckhead Urogynecology and staff if there are any changes to my medical status. I hereby consent to and authorize Buckhead Urogynecology and staff to perform any service that allows them to make a diagnosis and to provide effective treatment. I authorize my insurance benefits be paid directly to Buckhead Urogynecology. I understand that I am financially responsible for any balance. I also authorize Buckhead Urogynecology or my insurance company to release any information required to process my claims.

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Patient Signature Date

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Parent / Guardian signature if applicable Date