Needham Urology Associates

Affiliated with Beth Israel Deaconess Hospital Needham

Notice of Patient Privacy Practices

I acknowledge having received a copy of the practice's Notice of Privacy Practices from **Needham Urology Associates**.

_____ _____

Signature Date

Assignment of Benefits

I request that the payment of authorized medical benefits be made on my behalf to **Needham Urology Associates** for services rendered. I authorize any holder of medical information about me to release to the Health Care Financing Administration and it agents, or any other insurer, any information needed to determine those benefits payable for related services. A copy or a system generated printout of this release will be as valid as the original form. I acknowledge and agree that I am personally responsible for any co-payments and/or deductibles associated with the services I receive which are not covered by my insurance.

_____ _____

Signature Date

Consent for RX Hub Inquiry

I hereby provide my consent for **Needham Urology Associates** obtain my Rx History using the SureScripts-RxHub network. I understand that this inquiry will provide my physician with an accounting of my medication history reported by Pharmacy Benefit Managers and retail pharmacies. I also understand that SureScripts-Rx Hub has certified that Rx History Capture follows strict security protocols to align with HIPAA requirements and respect patient privacy. All queries and responses are made automatically through secure system-to-system communications.

_____ _____

Signature Date

_____

Print your name