HTX Urology
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PATIENT RESPONSIBILITY FORM

PLEASE INITIAL BESIDE EACH SECTION

1. I acknowledge that my physician is my partner in health. As an adult, it is my responsibility to keep track of my medical conditions, medications, and all other physicians that are involved in my medical care. It is my responsibility to inform every physician or other health care provider that I encounter about any changes in my medications, medication dosages, any medical conditions or any evaluations in progress. (Initial) _____

2. Test results are usually reviewed and discussed in the office at a follow-up appointment. I acknowledge that if I am NOT notified of any test results obtained or referred by this office, then it is my duty to contact the office to make arrangements to receive the results. I will not assume that not receiving results means tests are normal. I also understand that certain results may warrant a formal discussion and the doctor may require a follow-up appointment in lieu of a phone conversation. (Initial) _____

3. I acknowledge that if I fail to keep an advised follow-up appointment to go over test results, monitor treatment , or evaluate symptoms, then I am responsible if this results in harm to myself, delay in diagnosis, or failure to treat or cure. (Initial) _____

4. I acknowledge that I am responsible for scheduling my own appointments. As a courtesy – the physician's office will attempt to contact me one or two days prior to remind me of an appointment, however I may not receive this message for various reasons. (Initial) _____

5. I acknowledge the importance of making sure the physician's office has my current address and all phone number contacts. If my information on file is not current, then I acknowledge that my physician's office will not be able to notify me about abnormal test results, medication recalls, changes in appointment or surgery scheduling, etc. (Initial) _____

6. I acknowledge that I am responsible to know the insurance benefits provided by my insurance carrier(s). Any questions I have regarding my insurance benefits will be directed to my insurance carrier or Human Resources department by my guarantor or myself. (Initial) _____

_____ _____
Print Name Date of Birth

_____ _____
Signature Date