UROLOGY OF GREATER ATLANTA, LLC

CONSENT TO PAYMENT OF RESERVATION FEE

Important: Do not sign this form without reading and understanding its contents.

Urology of Greater Atlanta, LLC (the "**Practice**") is dedicated to providing comprehensive care in the medical specialty of urology. You wish to schedule one of the following procedures to be performed by the Practice physicians: percutaneous nephrolithotomy (PCNL), robotic prostatectomy, nephrectomy, or penile implant (each, the "**Procedure**"). To reserve your scheduled appointment for this Procedure, the Practice requires a reservation fee of One Thousand Dollars ($1,000.00) (the "**Reservation Fee**").

Please initial at each section below to which you agree, and sign at the bottom. "I," "my," or "me" refers to the patient, who may be you or another person for whom you are legally authorized to sign documents.

Consent to Reservation Fee

_____ I voluntarily agree to pay to the Practice the Reservation fee on the date of this Consent.

_____ I understand that the Reservation Fee is intended to reimburse the Practice for scheduling disruptions in the event I cancel my Procedure with insufficient notice. Accordingly, I voluntarily consent to the Practice retaining the Reservation Fee in its entirety if (1) I fail to show up timely for my appointment for the Procedure OR (2) I fail to cancel my appointment for the Procedure at least three (3) business days (Monday through Friday) before the scheduled date of my Procedure. I understand and agree that appointments may only be canceled by calling the Practice at 770-474-5281, Monday-Friday during its regularly scheduled office hours, and speaking with an attendant. Leaving a message will not constitute a timely cancellation.

_____ I understand that if I keep my appointment for the Procedure as scheduled, or if I cancel my appointment for the Procedure no less than three business days in advance of the scheduled date of my Procedure, the Practice will refund to me the Reservation Fee**, less any amounts I may owe the Practice that are outstanding at that time.**

_____ I understand that the Reservation Fee is in addition to any copayment or similar such cost-sharing amounts for which I may be responsible in connection with the Procedure, and I hereby agree to be responsible for and pay any and all such amounts.

By signing this form, I agree that I have read or had this form read and explained to me, that I understand it, and any and all questions I asked have been answered to my satisfaction.

With my signature, I acknowledge and agree to all of the above provisions set forth in this Consent. If signing as a parent or authorized representative, I hereby represent and warrant that I am legally empowered and entitled to do so on behalf of the patient.

Signature of Patient or Authorized Representative	**Date**
Reason Patient is Unable to Sign (if applicable)	**Relationship to Patient**