



**PLEASE FILL OUT COMPLETELY AND RETURN
BY MAIL PRIOR OR BRING TO YOUR APPOINTMENT**
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Patient Legal Name: _____
(Last) (First) (M.I.)

Patient Address: _____
(Street/PO Box) (City) (State) (Zip)

Patient Numbers: Home (_____) Work (_____) Cell (_____) _____

Patient Date of Birth ____/____/____ Age:____ Sex: M / F Patient Social Security No: _____

Referred by: _____ Clinic: _____

Family Physician: _____ Clinic: _____

Pharmacy: _____ Nursing or Group Home: _____

IMPORTANT who can be given information: _____
(name and relationship) _____

Responsible Party: _____ Phone No: _____

PRIMARY INSURANCE

Insurance Company Name: _____ Address: _____

Contract No: _____ Group No: _____

Subscriber Name: _____ Relationship: _____

Birth date: _____ Soc Sec No. _____

SECONDARY INSURANCE

Insurance Company Name: _____ Address: _____

Contract No: _____ Group No: _____

Subscriber Name: _____ Relationship: _____

Birth date: _____ Soc Sec No. _____

FINANCIAL AGREEMENT

I certify that I am the patient or that I am financially responsible for the services rendered and do hereby unconditionally guaranty the payment of all amounts when and as due. Facility employees are NOT able to define your insurance coverage. If you have coverage questions, you are advised to call your insurance carrier.

ASSIGNMENT OF BENEFITS

I hereby assign to and authorize payment directly to Adult & Pediatric Urology of all benefits due me and/or dependents under Medicare, Medicaid, or any insurance policy providing benefits for facility charges, for services rendered by the facility/physician/supervisor.

RELEASE OF RECORDS

I irrevocably agree that the facility may disclose, to the extent allowed by the law, my medical and financial record to any affiliate of the facility, specifically including (a) my referring and/or family physician, (b) any physician treating, consulting, or otherwise performing services for me, including his or her employees and agents, (c) insurance companies including Centers for Medicare and Medicaid Services, the Health Care Financing Administration and its agents, if applicable to determine those benefits payable for related services, any other governmental or accrediting agency, or their agents or employees, (d) the responsible party, (e) the person(s) I have listed above, and (f) myself.

Patient/Guarantor

Date

PRIVACY PRACTICE ACKNOWLEDGEMENT

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A photostatic copy of this agreement shall be considered effective and valid as the original.

€ Accepted Copy € Rejected Copy

Patient/Guarantor

Date