

UROLOGIC PHYSICIANS AND SURGEONS, PA

REFERRED BY: _____ CURRENT MEDICAL PROVIDER _____

PATIENT NAME _____ **DATE OF BIRTH** _____

SOCIAL SECURITY NO. _____ MALE / FEMALE (Circle)

LOCAL ADDRESS _____ CITY _____ STATE _____ ZIP _____

LOCAL PHONE 1 _____ LOCAL PHONE 2 _____ WORK PHONE _____

CELL PHONE _____ OUT OF TOWN PHONE () _____ FAX _____

OUT OF TOWN ADDR _____ CITY _____ STATE _____ ZIP _____

PATIENT'S EMPLOYER/ADDRESS _____

EMAIL _____ PHARMACY TEL _____



SPOUSE'S NAME (IF APPL) _____ **SP.DOB** _____

SP.PHONE _____ SP.CELL PHONE _____ SP.WORK PHONE _____

SP.EMPLOYER _____

EMERGENCY CONTACT (NOT SPOUSE) _____ **E.C.PHONE** _____



PRIMARY INSURANCE _____ **POLICY/ ID#** _____ **GROUP #** _____

PHONE(____) _____ **INSURED NAME** _____ **DOB OF POLICYHOLDER** _____

SECONDARY INS. _____ **POLICY/ ID#** _____ **GROUP #** _____

PHONE (____) _____ **INSURED NAME** _____ **DOB OF POLICYHOLDER** _____

IS THIS A WORKER'S COMPENSATION CLAIM ? YES____ NO____

INFORMATION RELEASE/AUTHORIZATION AND PAYMENT RESPONSIBILITY

I CERTIFY THAT ALL THE ABOVE INFORMATION IS ACCURATE. I HEREBY AUTHORIZE THE RELEASE OF ANY INFORMATION NECESSARY TO PROCESS MY CLAIMS. I HEREBY AUTHORIZE THE RELEASE OF MY MEDICAL INFORMATION TO MY REFERRING HEALTH CARE PROVIDER AS WELL AS TO THOSE I MAY BE REFERRED TO FOR CONSULTATION AND/OR TREATMENT. PAYMENT OF ANY GOVERNMENT BENEFITS MAY BE MADE EITHER TO MYSELF OR TO THE PARTY WHO CLAIMS ASSIGNMENT.

I AUTHORIZE THE PAYMENT OF MEDICAL BENEFITS DIRECTLY TO THE "UNDERSIGNED" PHYSICIAN. I AM FINANCIALLY RESPONSIBLE FOR ANY UNPAID BALANCE DUE.

I AGREE TO BE RESPONSIBLE FOR THE PAYMENT OF ALL CHARGES FOR MEDICAL SERVICES WITHIN 30 DAYS FROM THE DATE OF THE FIRST BILLING UNLESS OTHERWISE AGREED. I FURTHER AGREE TO PAY 1.5% COMPOUND INTEREST PER MONTH ON THE BALANCE WHICH IS UNPAID AFTER 60 DAYS UNTIL PAID. I UNDERSTAND ADDITIONAL MEDICAL SERVICES ON ACCOUNT ARE DUE UPON BILLING AND IF UNPAID WITHIN 60 DAYS WILL ACCRUE INTEREST ON THE UNPAID BALANCE AT 1.5% INTEREST. IN THE EVENT I DO NOT MAKE PAYMENT WHEN BILLED, I SHALL PAY THE COST OF COLLECTION, INCLUDING BUT NOT LIMITED TO ATTORNEYS FEES, COST OF SUIT AND AS PROVIDED ABOVE.

SIGNED _____ DATE _____