

The Ambulatory
Urosurgical Center



Doctor's Name: _____

Patient Account #: _____

Patient's Name: _____ Today's Date: _____
(Last) (First)

Patient's Address: _____
(Address) (Street) (Apt.) (City) (State) (Zip)

Patient's Home Phone #: _____ Cell Phone: _____

Social Security #: _____ - _____ - _____ Date of Birth: _____

Patient is: Male Female Patient is: Single Married Separated Divorced Widowed

Patient's Occupation: _____ Employer: _____

Employer's Address: _____ Work Phone: _____

Name of Primary Care Physician: _____

Primary Insurance Company: _____

Policy #: _____ Group #: _____

Name of Policyholder: _____ Relationship to the Patient: _____

Secondary Insurance Company: _____

Policy #: _____ Group #: _____

Name of Policyholder: _____ Relationship to the Patient: _____

Complete this section if you are not the Insurance Policyholder for any insurance listed above.

Policy Holder's Name: _____ Relationship to Patient: _____

Date of birth of Policy Holder: _____ Home Phone #: _____

Employer: _____ Work Phone #: _____

Policy Holder's Social Security #: _____ - _____ - _____

In Case of Emergency, Please Notify: Name: _____

Contact #: _____

Insurance and Authorization Assignment — The Ambulatory Urosurgical Center — Urological Consultants, P.A.

I hereby authorize this surgery center to apply for benefits on my behalf for covered services rendered. I request payment from my insurance company to be made directly to the above named provider. I certify that the information I have reported regarding my insurance coverage is correct. I authorize the release of any necessary information, including medical information, to my insurance company in order to determine insurance benefits. The authorization may be revoked by either my insurance company or myself at any time in writing.

In the event that the Ambulatory Urosurgical Center does not receive a referral, treatment plan, and/or authorization number for my procedure, I will be held responsible for any payment due.

I agree to be responsible for the balance of any fees my insurance company determines to be my responsibility, including any copay.

Authorized Signature: _____ Date: _____