

UROLOGICAL CONSULTANTS, PA

Referring / Primary Doctor _____
Doctor's Phone # _____

For Office Use Only
PATIENT
ACCOUNT #

PATIENT INFORMATION

Patient's Name: _____
Last First Middle

Patient's Address: _____
Street Apt # City State Zip

Home Phone: _____ Cell Phone: _____

Sex: _____ Marital Status: (please circle one) S M D W

Patient Occupation: _____ Employer: _____

Employer's Address: _____ Work Phone: _____

Date of Birth: _____ Age: _____ SS#: _____

Spouse's Name: _____ Work Phone: _____ Cell Phone: _____

INSURANCE INFORMATION

Primary Insurance: _____ Policyholder: _____
Policy ID #: _____ Group #: _____
Policyholder Soc. Sec. #: _____ Policyholder Date of Birth: _____
Relation to Policyholder: _____

Secondary Insurance: _____ Policyholder: _____
Policy ID #: _____ Group #: _____
Policyholder Soc. Sec. #: _____ Policyholder Date of Birth: _____
Relation to Policyholder: _____

AUTHORIZATION

ASSUMPTION OF RESPONSIBILITY

Your insurance policy is a contract between you and your insurance company. As a courtesy to you, we will bill all charges to the insurance company indicated above. We appreciate prompt payment from you of the balance after your insurance company pays.

AUTHORIZATION TO RELEASE INFORMATION / ANNUAL AUTHORIZATION

The undersigned hereby authorizes Urological Consultants, PA to release all information pertaining to patient's treatment to his/her insurance company or companies. (I permit a copy of this authorization to be used in place of the original)
I request the payment of authorized benefits for any services furnished to me by Urological Consultants, PA be made directly to Urological Consultants, PA.
I have read, understood and approved all of the above information.

MEDICARE PATIENTS ONLY - CMS ASSIGNMENT / ANNUAL AUTHORIZATION

I request payment of authorized Medicare benefits be made on my behalf to Urological Consultants, PA for any services rendered to me. I authorize any holder of medical information about me to release to Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

SIGNATURE: _____ DATE: _____