

Date: _____

Urology Associates, PC

Chart # _____

Patient Information:

_____	_____	_____	Male	Female
Last Name	First Name	MI	Circle One	
_____		_____	_____	_____
Street Address		City	State	Zip Code
_____	_____	Marital Status: Single Married Separated Divorced Widowed N/A		
Home Phone Number	Work or Cell Phone Number			
_____	_____	_____		
Social Security Number	Date of Birth	E-Mail Address		
_____	_____			
Occupation / Employer	Spouse			
_____	_____			
Father's Name / Legal Guardian	Mother's Name			
_____	_____			
Referring Doctor	Dr. Phone Number			
_____	_____			
Primary Care Doctor	Dr. Phone Number			

Responsible Party: To Whom We Should Send Statements To

_____	_____	_____		
Last Name	First Name	MI		
_____		_____	_____	_____
Street Address		City	State	Zip Code
_____	_____			
Home Phone Number	Work Phone Number			

Health Insurance Information: Please Provide Insurance Card

_____		_____		_____	
Name of Primary Insurance		Policy Identification Number		Group Number	
_____	_____	_____	_____	_____	
Policy Holder Last Name	Policy Holder First Name	MI	Date of Birth (required)	Social Security Number	
_____		Relationship:	Self	Spouse	Parent Other
Name of Employer					
_____		_____		_____	
Name of Secondary Insurance		Policy Identification Number		Group Number	
_____	_____	_____	_____	_____	
Policy Holder Last Name	Policy Holder First Name	MI	Date of Birth (required)	Social Security Number	
_____		Relationship:	Self	Spouse	Parent Other
Name of Employer					

Emergency Contact Information:

_____	_____	_____		
Last Name	First Name	MI		
_____		_____	_____	
Home Phone Number		Work Phone Number	Relationship to Patient	

Financial Policy for Patient Care Services

We ask that you read this policy and aid us in keeping the costs down by ensuring that we are able to be reimbursed for our services on a timely basis. We welcome the opportunity to discuss any aspect of our financial policy.

To help in this policy, we ask that you assist us by:

1. Providing us with current and updated information on yourself and your insurance company and to keep all changes up to date.
2. Make payment at the time of service for the entire balance if you are a self pay patient, or for the amount of any deductibles, co-pays, or past due balance that may be due.
3. Discuss your account balance only with the check-out or business staff. Please do not discuss the financial aspects of your care with the physician(s). It is important for them to be allowed to practice medicine and provide patient care. Please work with the rest of the office staff on any account questions or problems you may have. If they cannot help you or answer your questions to your satisfaction, then please, do not hesitate to contact the practice administrator.

I am authorizing the insurance company to pay any medical benefits for these services and all future claims to Urology Associates PC.

To help us provide the most efficient and reasonable health care services, it is necessary for us to have a financial policy stating our requirements for payment of services provided to our patients. Patients are responsible for the payment of all services provided by our office. It is our policy to file for insurance as a courtesy to you if we have accurate and complete insurance information. The balance due is still your responsibility if we have not received payment from the insurance company within 60 days.

If you have insurance and we file with your carrier, we ask that you pay ahead of time on the balance which is your responsibility according to your plan, ie. any deductibles, co-pay, co-insurance amounts. For Medicare patients, we will wait until we have received payment and then bill the patient for any remaining balance due. Since we are not a party to the agreement between you and your insurance company, we ask that you assist us in contacting them in the event that services are not paid within 60 days. You are also authorizing Urology Associates, PC or its employees to release any necessary information related to this visit and all future visits for the purposes of claim(s) payment.

If you do not have insurance and are not covered by either Medicare or Medicaid, you will be considered a "SELF PAY" patient. Payment is due in full at the time of service. This assists us in cutting down on billing and operating expenses. Failure to give notice 24 hours prior to your appointment may result in a \$50 fee for office appointments and \$100 fee for office procedures that you have scheduled.

If we need to forward your account over to a collection agency for further legal action, you will be responsible for the entire balance on your account plus any collection agency, attorney, or court fees.

Responsible Party or Authorized Person Signature

Date

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