

PATIENT INFORMATION

Please complete all information

Today's Date: / /

Have you ever been a patient with Spokane Urology in the past? Yes no Dr: Yr:

Referring Physician Primary Care Physician

Phone/Address: Phone/Address:

Primary Pharmacy Phone/Address:

Patient's Legal Name:

S.S.# Last First Middle Date of Birth Age: Sex M F Primary Language Spoken

Street Address City: State: Zip

Home Phone () Cellular Phone ()

Mailing address (if different from above)

Employer/Occupation: Work Phone ()

Marital Status: S M W D Spouse's name

Spouse's employer Work Phone ()

Nearest friend or relative (not living with you) Phone () Relationship

GUARANTOR INFORMATION (Person responsible for payment)

Primary Insurance Group # Subscriber #

Subscriber's name: Relationship Phone ()

Subscriber's S.S.# Date of Birth Sex: M F Marital Status S M W D

Employer/: Work Phone: ()

Employer address:

Secondary Insurance: Group # Subscriber #

Subscriber's name: Relationship Phone ()

Subscriber's S.S.# Date of Birth Sex: M F Marital Status S M W D

Employer: Work Phone: ()

Employer address:

Assignment of Benefits: I hereby assign all benefits for services by Spokane Urology and include major medical benefits to which I am entitled, including Medicare, private insurance, and any other health plan, and I ask that Spokane Urology or Dr: furnish all requested medical information of the person or entity named above. I understand that my records may contain information regarding the diagnosis of treatment of HIV (AIDS virus), or other sexually transmitted diseases, drug and/or alcohol abuse, mental illness or psychiatric treatment. I give my specific authorize-ation for these records to be released. This request is a free and voluntary act by me. (Statement required by law) This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as an original. I hereby authorize said assignee to release all information necessary to secure the payment. I understand that I am financially responsible to the provider for charges not covered by my benefit plan.

Signed Date Patient/other legally responsible person (signature and relationship)

**WE APPRECIATE THE OPPORTUNITY OF SERVING YOU
WE PLEDGE TO GIVE YOU OUR VERY BEST MEDICAL CARE.**

OFFICE POLICY ON PAYMENT:

It is our policy to require payment of all office charges at the time they are given, unless prior arrangements have been specifically made. All accounts over 60 days will be charged an interest rate of 1 ½ percent per month (18% per anum) or a \$3.00 minimum. In the event any balance due hereunder is not paid as agreed, the undersigned jointly and severally agree to pay all costs charged by the collection company, which costs will not exceed 20% of said unpaid balance, including a reasonable attorneys fee.

INSURANCE POLICY:

Insurance providers for your reimbursement on allowed medical charges. As a courtesy to you, we will provide an itemized statement you may send to your insurance company for payment. We will be happy to submit to most insurance carriers, if you have provided us with policy numbers, address, place of employment, and any other pertinent information. You are responsible for all deductibles and charges not covered by insurance. Please understand that we cannot, as a third party, become involved in prolonged insurance negotiations, this is your responsibility.

I authorize the release of any medical information necessary to process any claim. I permit a copy of the authorization to be used in place of the original. This authorization may be revoked by either me, or my insurance company at any time in writing.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS:

I authorize the Doctor to release any medical information including diagnosis, x-rays, test results, reports and records pertaining to any treatment or examination rendered to me. I understand that this medical information may be used for any of the following purposes: diagnostic, insurance, legal and at times when the Doctor deems it necessary in order to ensure the best medical care on my behalf. I further understand that any person(s) that receive these medical records will not release any of the medical information obtained by this authorization to any other person or organization without a further authorization signed by me for release of the information.

SIGNED: _____ **Date:** _____
Patient, Parent or Guardian

ONE TIME AUTHORIZATION

I authorize any holder of medical or other information about me to release to the Social Security Administration and Center for Medicare and Medicaid Services (CMS) or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information.) Regulations pertaining to Medicare assignment of benefits also apply.

Signature: _____ **Date:** _____

In case of emergency, please contact:

Name: _____

Phone Number: () _____ Relationship: _____

Address: _____