

PATIENT INFORMATION SHEET

ACCOUNT# _____

LAST NAME: _____

FIRST NAME: _____

INITIAL _____

DATE OF BIRTH _____

MALE

FEMALE

STREET ADDRESS _____

APT. # _____

(_____) HOME TELEPHONE # _____

CITY _____

STATE _____

ZIP CODE _____

(_____) CELL TELEPHONE # _____

MARRIED SINGLE
MARITAL STATUS

F-TIME P-TIME
EMPLOYED

SOCIAL SECURITY# _____

EMPLOYER _____

WORK TELEPHONE # _____

REFERRING DOCTOR _____

DOCTORS TELEPHONE # _____

ALLERGIES _____

CURRENT MEDICATIONS _____

MALE

FEMALE

SPOUSE'S (PARENT) LAST NAME: _____

SPOUSE'S (PARENT) FIRST NAME: _____

INITIAL _____

DATE OF BIRTH _____

SPOUSE'S (PARENT) SOCIAL SECURITY NUMBER _____

(_____) SPOUSE'S (PARENT) CELL TELEPHONE # _____

SPOUSE'S (PARENT) EMPLOYER _____

(_____) SPOUSE'S (PARENT) WORK TELEPHONE# _____

EMERGENCY CONTACT (Nearest Friend/Relative Not Living With You)

(_____) HOME TELEPHONE # _____

(_____) WORK TELEPHONE # _____

(_____) CELL TELEPHONE # _____

PRIMARY INSURANCE: _____

(_____) INSURANCE COMPANY TELEPHONE # _____

POLICY HOLDERS NAME _____

POLICY HOLDERS SS# _____

POLICY HOLDERS EMPLOYER NAME _____

RELATIONSHIP TO PATIENT _____

SECONDARY INSURANCE: _____

(_____) INSURANCE COMPANY TELEPHONE # _____

POLICY HOLDERS NAME _____

POLICY HOLDERS SS# _____

POLICY HOLDERS EMPLOYER NAME _____

RELATIONSHIP TO PATIENT _____

I certify that I am covered only by the insurance noted above and that as of this date this information is true and correct. I authorize _____ Mid Atlantic Urology Associates, LLC. to apply for benefits on my behalf for covered services. I request that my insurance company pay benefits directly to _____ Mid Atlantic Urology Associates, LLC. I authorize the release of any necessary information to my insurance carrier for this or any related claim. I permit the use of a copy of this authorization to be used in place of the original. I understand that you are filing my claim with my insurance company as a courtesy and agree that I am ultimately responsible for the balance on my account for any professional services rendered to me, regardless of my insurance status.

SIGNATURE OF PATIENT OR GUARANTOR _____

DATE _____

OVER →

INSURANCE INFORMATION

Please give our secretary your insurance card(s) and driver's license, which she will photocopy and return to you. If you do not have your insurance card(s) with you, fill in all information (primary and secondary) in the appropriate section the other side of this sheet. Please write **NONE** in the secondary insurance block if you are covered by only one insurance policy.

If you tell us you have only one insurance policy and, at a later date, ask us to file claims for other insurance, you will be require to pay:

*\$50.00 for each additional insurance claim we must file (or re-file) for coordination of benefits.

*The balance in full for all claims your insurance carriers refuse to pay because you withheld information that caused claims to be filed after their deadline date.

PATIENT ACCOUNT INFORMATION

All patients that do not have HMO insurance or Medicare with secondary coverage are required to pay 20% of their office visit at the time of service. For these patients we will also require a \$100.00 pre-payment for any diagnostic/surgical procedure.

Any account over 30 days will incur a re-bill (finance) charge of 1.5% per month. If a payment plan has been set up and adhered to this charge will not apply.

Any account that has been sent to the collection agency is required to be paid in full (in cash) prior to your next office visit. We also require a collection patient to pay the fee for his/her collection balance that we have been charged by the agency to collect your balance.

OFFICE APPOINTMENTS

PLEASE BE ADVISED THAT THERE WILL BE A \$25.00 FEE CHARGED TO YOUR ACCOUNT, NOT YOUR INSURANCE COMPANY, FOR OR ANY AND ALL NO-SHOW APPOINTMENTS OR CANCELLED APPOINTMENTS IF NOTICE IS LESS THAN 24 HOURS.

*****RELEASE OF MEDICAL INFORMATION/RECORDS*****

If you require a copy of your medical records, the following is required:

- a. A written request from you and the address where you wish the records to be sent.
- b. A picture ID for verification purposes.

We will not release your medical information to any person other than you without your prior written consent. The only exception to this is if our patient is a minor, then we will only release the information to the patient or guardian completing this form. If you wish to have your medical information available to someone other than yourself:

PLEASE LIST THEIR NAME/RELATIONSHIP BELOW.

NAME

RELATIONSHIP TO PATIENT

BY SIGNING BELOW I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND ALL INFORMATION STATED ABOVE.

PATIENT'S SIGNATURE

Mid Atlantic Urology Associates, LLC.

Permission to Release Medical Information

Patient: Required by Federal Law

I, _____ hereby give permission to Mid Atlantic Urology Associates, LLC., its employees, and sub-contractors to release current, past and future information about my medical condition, diagnoses, treatments and recommendations to:

(Cross out any that do not apply, other than the top six , (*in italics*), that are required for us to care for you)

- *My present and future health insurers*
- *My referring or primary health care provider*
- *Other health care providers caring for me*
- *Health care providers/laboratories I am referred to*
- *Health care facilities I am referred or admitted to*
- *Authorized reviewers for regulatory compliance quality assurance and/or peer review*
- My spouse or *significant other* _____
- My parents _____
- My employer (required for compensation cases)
- Others _____

This permission will remain in effect until I revoke all or part of it in writing. I understand Mid Atlantic Urology Associates ,LLC.will make reasonable efforts to insure my privacy, but cannot guarantee the conduct of others who receive this information as allowed above.

Signed _____ Date _____

Witness _____

Guardian for Dependant:

I, _____ hereby give permission to Mid Atlantic Urology Associates , LLC its employees, and sub-contractors to release current, past and future information about _____'s, diagnoses, treatments and recommendations to:

(Cross out any that do not apply, other than the top six , (*in italics*), that are required for us to care for you)

- *His/her present and future health insurers*
- *His/her referring or primary health care provider*
- *Other health care providers caring for him/her.*
- *Health care providerslaboratories he/she is referred to*
- *Health care facilities he/she is referred or admitted to*
- *Authorized reviewers for regulatory compliance quality assurance and/or peer review*
- His/her spouse or *significant other* _____
- His/her parents _____
- His/her employer (required for compensation cases)
- Others _____

This permission will remain in effect until I revoke all or part of it in writing. I understand that Mid Atlantic Urology Associates ,LLC PA will make reasonable efforts to insure his/her privacy but cannot guarantee the conduct of others who receive this information as allowed above.

Signed _____ Date _____

Witness _____