

UROLOGIST: _____
ACCOUNT NUMBER: _____
PHARMACY: _____ PHARMACY PHONE #: _____

PATIENT INFORMATION

Last Name _____ First Name _____ Middle Name _____ DOB ____/____/____
 Male
 Gender Female Social Security # _____ Race _____ Marital Status Single Divorced
 Married Widowed Separate
 Driver's License # _____ Religion _____
 Address _____ Zip _____ City _____ State _____
 Home Phone # () _____ Work Phone#() _____ Cell Phone#() _____ Email _____
 Employer _____ Occupation _____ Employer's Phone _____

RESPONSIBLE PARTY

IF PATIENT IS NOT RESPONSIBLE FOR THE BILL, PLEASE INDICATE WHO IS RESPONSIBLE

First Name _____ Middle Name _____ Last Name _____
 Responsible Party Address _____ City _____ State _____ Zip _____
 Phone # () _____ Soc. Sec. No. _____ Relationship _____ DOB ____/____/____

PATIENT CONTACT INFORMATION

Urology Centers of Alabama, PC and its staff has my permission to discuss my account or medical conditions which may include symptoms, treatments, tests, medicine or other protected health information with the following persons to facilitate my treatment and payment of my account.

Name _____ Relationship _____ Phone _____
 Name _____ Relationship _____ Phone _____

I understand authorizing the release of this information is voluntary and does not affect my access to treatment. I can refuse to make this authorization. I understand this authorization will remain effective until I revoke it by completing a new form. I understand if this information is shared with these individuals above, that they may disclose my protected health information to other individuals. I have indicated my agreement with this authorization by signing below.

REFERRAL INFORMATION

Primary Care Physician Referred by _____ Phone Number _____
 This is my Doctor Relative Friend or Other _____

INSURANCE INFORMATION

Blue Cross of Alabama Contract # _____ Is This PMD: Yes No
 Medicare Contract # _____ Do You Have Part B? Yes No
 Medicaid Contract # _____
 Does Your Insurance Require A Referral? Yes No Do You Have A Waiting Period? Yes No How Long? _____ How Much is Your Co-Pay? _____
 Other Insurance: Name: _____ Contract # _____ Group # _____
 Insured: Name: _____ Address: City: _____ State: _____ Zip: _____
 Phone # () _____ Relationship to Insured: Self Child Spouse Other Birthdate: ____/____/____ Gender: Male Female
 Employer: _____ Insured Social Security # _____ Effective Date of Insurance: _____
Which Insurance is Primary? _____

I accept full responsibility for all charges for service rendered by Urology Centers of Alabama, PC. I agree to pay all costs of collection, including reasonable attorney fees. I authorize the release of any medical information necessary for the completion of insurance claim forms. I assign all benefits under my current health insurance policies and authorize payment directly to Urology Centers of Alabama, PC of any medical or government benefits due from my insurance and/or government program. I understand my insurance may not pay all of my charges and I agree to promptly pay the difference or the entire bill. I have received a copy of the Notice of Privacy Practices statement. I have authorized Urology Centers of Alabama, PC to discuss my protected health information with the above named individuals. I have read all of the information on the reverse side of this form and I agree to these policies.

Patient's or Authorized Representative's Signature _____ Date _____ Email _____

INSURANCE IS FILED AS A COURTESY. CO-PAYMENTS ARE EXPECTED AT TIME OF SERVICE - THANK YOU