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Patient Information

Date: _____

Patient Name (Last, First, Middle Initial): _____

Local Address: _____

City: _____ State: _____ Zip: _____

☐ Male ☐ Female Social Security #: _____

Birth Date: _____ / _____ / _____ Age: _____

Local Phone: (_____) _____ Cellular Phone: (_____) _____

Email Address: _____

Home Away Address: _____

City: _____ State: _____ Zip: _____

Away Phone: (_____) _____

Patient's Employer: _____ Work Phone: (_____) _____

Marital Status: _____ Spouse's Name: _____

Spouse's Employer: _____ Work Phone: _____ (_____)

Spouse's Social Security #: _____ Spouse's Birth Date: _____/_____/_____

Nearest relative not living with you: _____ Phone: (_____) _____

Whom may we contact in case of emergency?: _____

Phone: (_____) _____

Who is your primary physician?: _____ Phone: (_____) _____

Your preferred pharmacy: _____ Phone: (_____) _____

New Policy for Notification of Test Results

Due to federal guidelines, the practice is implementing a policy for notifying our patients about their test results.

Call Home # _____ Work # _____ Phone # _____

Please check the following which apply:

☐ I approve you to leave message on answering machine or voice mail.

☐ I approve you to leave message with person answering the phone.

This authorization will be valid until we receive further notification from you.

Patient's Signature: _____ ***Date:*** _____

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UROLOGY

Patient Information *(cont.)*

Consent For Use And Disclosure Of Health Information

In addition to the authorization for release a my Protected Health Information, I furthermore acknowledge that I have the right to authorize access and disclosure of my Protected Health Information (PHI) to anyone of my choosing for billing, condition, treatment and prognosis to the following individual(s):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I request the following restriction(s) to releasing my PHI: _____

_____

_____

_____

I understand that I am entitled to a copy of Encore Urology's Notice of Privacy Practices. I can access a copy of the Notice of Privacy Practices from the website (www.encoreurology.com) or from the office directly.

I understand that I have the right to revoke this authorization, in writing, at anytime. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. Unless otherwise revoked this authorization shall be in force and effect one year from today's date at which time this authorization expires.

Patient's Signature: _____ ***Date:*** _____

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Patient Information *(cont.)*

Responsible Party Information

Name: _____

Phone: (_____) _____

Address: _____

City: _____ State: ____ Zip: _____

Relationship with Patient: _____

Responsible Person SS#: _____-_____-_____ DOB:_____ / _____ / _____

Employer's Name:_____

Phone: (_____) _____

Address: _____

City: _____ State: ____ Zip: _____

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay a fixed allowance for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductable amount, co-insurance, and other balance not paid for by your insurance company.

Method of Payment: ☐ Cash ☐ Check ☐ Credit Card

If payment is not made in full, I agree to pay all costs of collection, including attorney fees. I authorize Encore Urology to furnish information to all insurance carriers concerning my illness and treatment and I hereby assign to Encore Urology all payment for medical services rendered to me (the patient) or my dependents, in the event an insurance claim is filed by the practice. I further agree that a photocopy of this agreement shall be as valid as the original.

Patient's Signature:_____ Date: _____

Parent/Guardian Signature (if minor):_____