

encore UROLOGY

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?: _____

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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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 deductible 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): _____