

UROLOGY ASSOCIATES, P.C.

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LAST NAME _____ FIRST NAME _____ M.I. _____

BIRTHDATE ____ / ____ / ____ SEX M F SOCIAL SECURITY # _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME TEL. _____ BUS. TEL. _____ SPOUSE/PARENTS _____

PATIENT'S/PARENTS EMPLOYER _____ OCCUPATION _____

FAMILY PHYSICIAN _____ REFERRING PHYSICIAN _____

INSURANCE INFORMATION

<u>PRIMARY</u>	<u>SECONDARY</u>
NAME OF INS. CO. _____	NAME OF INS. CO. _____
INSURED'S NAME _____	INSURED'S NAME _____
DOB _____ SS# _____	DOB _____ SS# _____
POLICY ID NUMBER _____	POLICY ID NUMBER _____
PATIENT'S RELATIONSHIP TO INSURED?	PATIENT'S RELATIONSHIP TO INSURED?
<input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD	<input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD

PLEASE NOTE:

- 1. If we participate with your insurance and your plan requires a REFERRAL, YOU are responsible to obtain one from your Primary Care Physician.**
- 2. If your insurance requires you to use a SPECIFIC LAB, please inform the Nurse or the assistants.**

Fee Policy

Patients are expected to pay at the time services are rendered. Patients are responsible for payment in full for all coinsurance and deductible costs, as well as any doctor's services which are determined to be non-covered or denied.

INSURANCE AUTHORIZATION AND ASSIGNMENT

Name of Policy Holder _____ HIC Number _____

I request that payment of authorized Medicare/Other insurance company benefits be made either to me or on my behalf to _____ for any services furnished me by that party who accepts assignment/physician. Regulations pertaining to Medicare assignment of benefits apply.

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim other Insurance Company 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).

Signature _____

Date _____