

**UROLOGY ASSOCIATES OF SOUTH BEND
PATIENT INFORMATION SHEET**

DATE _____

Last Name _____ First Name _____ MI _____

SS# _____ - _____ - _____ Date of Birth _____ - _____ - _____ Age _____ Gender M F

Street Address _____ City _____ State _____ Zip _____

Home Phone (____) _____ Cell (____) _____

Family Physician _____ Phone (____) _____ City/State _____

Referring Physician _____ Phone (____) _____ City/State _____

Marital Status M S W D Employment Status: Student Retired Unemployed Employed Disabled

Employer _____ Work Phone _____

Address _____ City/State _____ Zip _____

MEDICAL INFORMATION RELEASE

I hereby authorize Urology Associates of South Bend to release any medical or appointment information to the following persons (eg: spouse, mother/father, children, friends, etc.)

<u>Name</u> (List Emergency Contact First)	<u>Relationship</u>	<u>Phone #</u>
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____

INSURANCE INFORMATION

1ST/Primary Insurance Co. _____ Policyholder Name _____

ID# _____ Group # _____ Employer Insurance Plan? Y N

2nd/Secondary Insurance Co. _____ Policyholder Name _____

ID# _____ Group # _____ Employer Insurance Plan? Y N

RESPONSIBLE PARTY INFORMATION (If not Patient) / PARENT INFORMATION (If a Minor)

Last Name _____ First Name _____ MI _____

Street Address _____ City/State _____ Zip _____

Phone (____) _____ Relationship to Patient _____ Gender M F

Date of Birth _____ - _____ - _____ SS# _____ - _____ - _____

Employer _____ Work Phone (____) _____ City/State _____

PLEASE SIGN THE BACK OF THIS FORM

HIPAA ACKNOWLEDGEMENT

As required by law, patients who receive health care services are entitled to receive a copy of the HIPAA Privacy Regulations. Please sign below that you (or your personal representative) have been offered a copy of the 2010 HIPAA changes. You may retain a copy for your records. Thank you.

Patient or Personal Representative Signature

Date

Relationship to Patient if Signed by Personal Representative

Date

INSURANCE ASSIGNMENT, RELEASE OF INFORMATION AND FINANCIAL AGREEMENT

I agree to pay Urology Associates of South Bend their charges for all services rendered during my treatment. I assign to Urology Associates of South Bend direct payment of any health insurance benefits, including Medicare benefits, Medicare Supplement or Medigap benefits, related to this treatment. I authorize the collection of these funds on behalf of Urology Associates of South Bend. Payments, however, will not exceed my balance owed. I acknowledge and understand that I and any guarantor signing on my behalf are personally responsible for any charges not paid by assignment of insurance benefits. I also acknowledge and understand that Urology Associates of South Bend will not accept responsibility for negotiating a settlement on any disputed claim. Past due accounts may be transferred to a collection agency. Any such accounts may be assessed a thirty percent (30%) collection fee based on the balance of the account. I understand that the account balance, any interest that may be accrued at the current legal rate, and all collection fees and costs, including reasonable attorneys' fees and expenses, are my responsibility.

I authorize any holder of medical or other information about me to release any information needed to determine health insurance benefits for these services. I hereby certify that any information which I have given in applying for coverage under Title XVII and/or Title XIX of the Social Security Act, or any insurance or other information which I provided is true and correct.

Patient Signature

Date

Patient's Legal Guardian or Responsible Party's Signature (if applicable)

Date