

UROLOGIST: _____

ACCOUNT NUMBER: _____

PHARMACY: _____ PHARMACY PHONE #: _____

PATIENT INFORMATION

Last Name _____ First Name _____ Middle Name _____ DOB ____/____/____

Male Female Social Security # _____ Marital Status Single Divorced Married Widowed

Driver's License # _____ Ethnicity Hispanic Not Hispanic Declined Unknown

Race American Indian/Alaska Native Asian Nat Hawaiian/Pacific Islander Black or African American White Other
 Declined Unknown

Address _____ Zip _____ City _____ State _____

Primary Phone () _____ Secondary Phone () _____ Email _____

Employer _____ Occupation _____ Employer's Phone _____

What is your preferred method for receiving notices about your follow up care such as lab results? Email/Patient Portal Mail Phone Call

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. # _____ Relationship _____ DOB ____/____/____

EMERGENCY HEALTH / INFORMATION RELEASE

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 _____ Phone Number _____

Referred by This is my Doctor Relative Friend or Other _____

INSURANCE INFORMATION

Primary Insurance _____ Contract # _____

Secondary Insurance _____ Contract # _____

Other Insurance _____ 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? _____

If the name on the insurance card is not the patient, complete the section below

Insured: Name: _____ Address: City: _____ State: _____ Zip: _____

Phone () _____ Relationship to Insured: Self Child Spouse Other Birthdate: ____/____/____ 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 _____

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

BECAUSE THIS INFORMATION IS USED BY VARIOUS GOVERNMENT AND PRIVATE INSURANCE PROGRAMS, SEE SEPARATE INSTRUCTION ISSUED BY APPLICABLE PROGRAMS.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes releases of any information necessary to process the claim and certifies that the information provided is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. Sese 42 CFR 411.24 (a). In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge, and the patient is responsible only for deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted, CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by HCFA, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA and Black Lung programs. Authority to collect information is in section 205 (a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24 (a) and 424.5 (a) (6), and 44 USC 3101; 41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you receive are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third party payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are No penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 11288 of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the Computer Matching and Privacy Protection Act of 1988, permits the government to verify information by way of computer matches.

NON-COVERED ROUTINE SERVICES POLICY

Attention: Medicare, Blue Cross PMD, United Healthcare, Health Springs, and any other PPO or HMO which we accept.

As our patient, we want to provide you the best care possible. There may be certain routine services, that we feel are necessary for the maintenance of good health that are not covered by your insurance contract or that may be considered medically unnecessary. For example, we may order lab tests, Chest X-Ray, EKG or Injections that may not be covered by your contract. Let us reassure you that we will order only tests that we feel are necessary for your treatment and care. We will generally advise you if we anticipate a service that will not be covered.

I understand that some procedures done by my physician are not covered or may be considered unnecessary by my individual contract with Medicare, Blue Cross PMD, United Healthcare, Health Springs or other PPO, HMO; I accept the responsibility and agree to pay for services not covered by my contract.