

**DEMOGRAPHICS**

Patient Name: \_\_\_\_\_ Also Known As: \_\_\_\_\_  
Weight \_\_\_\_ Height \_\_\_\_  
Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Age: \_\_\_\_\_ SSN#: \_\_\_\_\_ Sex: \_\_\_\_\_  
Referring Dr: \_\_\_\_\_ Primary Dr.: \_\_\_\_\_  
Work Phone#: \_\_\_\_\_ Home Phone#: \_\_\_\_\_  
Employer: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_  
Email: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Spouse's Date of Birth: \_\_\_\_\_  
Spouse's Work Phone#: \_\_\_\_\_ Spouse's Mobile Phone#: \_\_\_\_\_

PREFERRED PHARMACY NAME: \_\_\_\_\_  
PREFERRED PHARMACY ADDRESS: \_\_\_\_\_

**MEDICAL INSURANCE INFORMATION**

Primary Insurance: \_\_\_\_\_ Contract #: \_\_\_\_\_  
Group #: \_\_\_\_\_  
Secondary Insurance: \_\_\_\_\_ Contract#: \_\_\_\_\_  
Group#: \_\_\_\_\_  
Name of Insured: \_\_\_\_\_ Certificate Suffix: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

**EMERGENCY CONTACT**

Name: \_\_\_\_\_ Phone#: \_\_\_\_\_ Relationship: \_\_\_\_\_

**PERMISSION TO RELEASE INFORMATION**

I authorize Victoria Urological Associates, P.A. (VUA) to release all medical information requested by my health insurance carrier, Medicare or any other third party payers. I authorize VUA to release all medical information to my referring physician and my primary (family) physician. I authorize VUA to contact Medicare, BCBS, Medicaid, or any other health plan administrator and obtain all pertinent financial information concerning coverage and payments under my policy. I direct Medicare, BCBS, Medicaid or any other health plan administrator to release such information to VUA. I authorize access and release of confidential patient information by VUA for purposes of photocopying the information in response to properly authorized requests for copies of patients' medical records.

If you anticipate the need for anyone else (spouse, family members, close friend, etc) to have access to this information please complete the information below:

<b>Name</b>	_____	<b>Relationship</b>	_____
	_____		_____
	_____		_____

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**ASSIGNMENT OF BENEFITS**

I hereby assign to Victoria Urological Associates, P.A. (VUA) any Medicare, Medicaid, or any other third-party benefits available for health care services provided to me. I understand that VUA has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to VUA, I agree to forward to VUA all health insurance and other third-party payments that I receive for services rendered to me immediately upon receipt. I also recognize that any co-pay amount my insurance requires me to pay is due at check-in and any deductibles, coinsurance, etc. will be due at check-out.

I understand that VUA agrees to file claims on all accepted benefit assignments in a timely manner. If such claims are not responded to by my insurance company in some fashion within thirty days then VUA will convert the remaining balance over to me and I will be responsible for the full charge.

The Patient and Responsible Party agree to be financially responsible to VUA regardless of coverage and coverage limits and that failure to make payment when due is the basis for legal action and may be subject to a 1.5% monthly finance charge. The Patient and Responsible Party agree that their financial obligation is joint and several and that VUA may pursue either or both parties for payment.

Patient (Agreement to Pay): \_\_\_\_\_ Date: \_\_\_\_\_

Guarantor (Agreement to Pay): \_\_\_\_\_ Date: \_\_\_\_\_