

Patient Name: _____ Date of Birth: _____
Street Address: _____ City: _____ Zip: _____
Home Telephone: _____ Sex: M or F Marital Status: _____ SS# _____
Cell Phone: _____ Referring Doctor: _____ Family Doctor: _____
I authorize Tri County Urologic Associates, P.C. to release medical information about my condition to the following person(s):

Relationship: _____ Phone # _____

Relationship: _____ Phone # _____

Employment Status: (Circle one) Employed Unemployed Retired Full/Part-time Student

Occupation: _____ Employer: _____

Employer's Address: _____ Work Phone: _____

Parent or Spouse's Name: _____ Date of Birth: _____

Person Responsible for Bill (if other than patient) : _____ SS# _____

Street Address: _____ City/State: _____ Zip: _____

Relationship to Patient: _____ Date of Birth: _____ Telephone: _____

PRIMARY INSURANCE: _____ Telephone: _____
Address: _____ City/State: _____ Zip: _____
Agreement # _____ Group # _____ Plan Type: _____
Subscriber's Name: _____ Relationship to Patient: _____
Subscriber's Date of Birth: _____ Subscriber's SS# _____

SECONDARY INSURANCE: _____ Telephone: _____
Address: _____ City/State: _____ Zip: _____
Agreement # _____ Group # _____ Plan Type: _____
Subscriber's Name: _____ Relationship to Patient: _____
Subscriber's Date of Birth: _____ Subscriber's SS# _____

ALL FEES FOR PROFESSIONAL SERVICES RENDERED ARE THE RESPONSIBILITY OF THE PATIENT. NECESSARY FORMS WILL BE COMPLETED TO HELP EXPEDITE INSURANCE CARRIER PAYMENTS. ALL FEES ARE TO BE PAID AT THE TIME OF SERVICE, UNLESS YOU HAVE AN INSURANCE WITH WHICH WE PARTICIPATE. ALL COPAYS ARE DUE AT THE TIME OF SERVICE.

INSURANCE AUTHORIZATION/ASSIGNMENT & RELEASE OF MEDICAL INFORMATION
I request that payment of authorized Insurance Company Benefits be made directly to Tri County Urologic Associates, P.C. or to me personally for any service furnished to me. I authorize Tri County Urologic Associates, P.C. to release any medical information necessary to process my insurance claims.

I understand I am financially responsible to Tri County Urologic Associates, P.C. for payment of services rendered. This includes any non-assigned benefits, deductible and coinsurance amounts, insurance co-pays and non-covered services.

SIGNATURE OF PATIENT (or responsible party) _____ DATE _____