SPOKANE UROLOGY

PATIENT INFORMATION *PLEASE COMPLETE ALL INFORMATION*

DATE:_____

Patient Legal Name:_____
Last First Middle

SS#:_____ **Date of Birth**:_____ **Age**: _____

Gender: ___Male ___ Female **Marital Status**: S D M W O **Spouse's Name**:_____

Ethnicity: ___Hispanic ___Non-Hispanic **Primary Language**:_____

Race: __Caucasion __Black __Asian __Indian/Alaska __Pac Isle __Other/Mult

Street Address:_____**City:**_____**State:**_____**Zip**_____

Mailing Address: (if different from Above) _____

Home Ph. No:_____ **Work Ph. No**:_____ **Cell No**:_____
Preferred contact phone number: **Home** **Work** **Cell** (please circle one)
I authorize Spokane Urology and their agents to contact me at the above numbers provided.
In Case of Emergency, Please contact:

_____
Name Phone No. Relationship
Email Address:_____

Primary Care Physician: _____ Phone No:_____
***Referring Physician*:**_____ Phone No:_____
Primary Pharmacy:_____location:_____

Reason for your visit today:_____

GUARANTOR INFORMATION (Person or entity financially responsible for payment)

Name:_____ **Relationship to Patient**:_____

Skilled Nursing Facility_____
Name Address
Home Health Agency_____
Name Address
Hospice:_____
Name Address

_____ _____
Signature of Responsible Party **Date**

My signature verifies that I have provided valid information to enable Spokane Urology to provide Medical Treatment to me and to seek payment from any entity that may be responsible for payment. Failure to provide valid information may result in my financial responsibly for payment in full.

INSURANCE INFORMATION:

Primary Insurance:_____**Policy#**_____**Group#**_____
If policy holder is different from the patient, please provide Subscriber information below:

Subscribers Name:_____**DOB**:_____ **Gender M F** **SS#:**_____

Employer:_____

Does your Insurance Carrier Require a Referral/authorization to see a specialist? ___ Yes ___No
If Yes. Do you have a valid referral to be treated by our physicians today? ____Yes ____No
If you do not have a valid referral (authorization) to see our urologist today you will be financially responsible for this visit and any visits that are not authorized by your insurance carrier.

Secondary Insurance:_____**Policy#**_____**Group#**_____
If policy holder is different from the patient, please provide Subscriber information below:

Subscribers Name:_____ **DOB**:_____ **Gender M F** **SS#:**_____

Employer:_____

Due to the multiple ongoing changings in the health care industry and to ensure that we have the most up to date and accurate insurance information, we now require you to present a valid insurance card at each visit. We will only have to copy your card if any of your insurance information has changed since your last visit. We want to do the best job possible in collecting payment from your insurance carrier. We appreciate your cooperation by presenting your insurance card each visit.

ASSIGNMENT OF BENEFITS & RELEASE OF INFORMATION:

I request that payment of authorized insurance benefits, including Medicare, if I am a Medicare beneficiary, be made on my behalf to Spokane Urology for any equipment or services provided to me by Spokane Urology.

I authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for related equipment or services to Spokane Urology, the Health Care Financing Administration, my insurance carrier or other medical entity. A copy of this authorization may be sent to the Health Care Financing Administration, my insurance company or other entity if requested. The original scanned authorization will be kept on file by Spokane Urology and I permit a copy of the authorization to be used in place of the original. I can revoke this authorization in writing at any time.

I understand that I am financially responsible to Spokane Urology for any charges not covered by health care benefits. It is my responsibility to notify the organization of any changes in my health care coverage. In some cases exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by the organization and/or my health care insurer if the submitted claims or any part of them are denied for payment. I understand that by signing this form I am accepting financial responsibility as explained above for all payment for services and products received.

This agreement shall be governed and enforced in accordance with the laws of the State of Washington. Jurisdiction and proper venue for enforcement shall lie in Spokane County, State of Washington.

Printed name of person signing below:_____

Relationship to Patient if other than patient:_____

Signature of Insured or Parent/Guardian: _____ _____
DATE