COLUMBIA UROLOGICAL ASSOCIATES, P.A.

WELCOME TO OUR PRACTICE!

DATE:_____ **REFERRING PHYSICIAN:**_____ **ACCT #:**_____

PATIENT NAME:_____
LAST **FIRST** **INITIAL**

MAILING ADDRESS:_____
STREET **CITY** **STATE** **ZIP CODE**

PHONE: (HOME)_____ **(CELL)** _____ **(WORK)**_____

EMAIL ADDRESS:_____

AGE:_____ **BIRTHDATE:**_____ **RACE:**_____ **SEX:**_____

EMERGENCY CONTACT NAME AND PHONE NUMBER OF SOMEONE NOT LIVING WITH YOU:

_____

EMPLOYMENT/SCHOOL INFORMATION

SOCIAL SECURITY #:_____

ARE YOU EMPLOYED?_____ **EMPLOYER:**_____ **PHONE:**_____

ARE YOU RETIRED OR DISABLED?_____ **IF SO, WHEN?**_____

ARE YOU A STUDENT?_____**NAME OF SCHOOL/UNIVERITY:**_____

SPOUSE/GUARDIAN INFORMATION

NAME OF SPOUSE OR PARENT:_____ **BIRTHDATE:**_____

EMPLOYER:_____ **PHONE:**_____**SOCIAL SECURTY #:**_____

PRIMARY INSURANCE INFORMATION

INSURANCE CO. NAME/ADDRESS:_____

ID #:_____**GROUP NAME:**_____ **GROUP #:**_____

NAME OF INSURED:_____**SOCIAL SECURITY#:**_____

RELATIONSHIP TO INSURED:_____**EFFECTIVE DATE:**_____

SECONDARY INSURANCE INFORMATION

INSURANCE CO. NAME/ADDRESS:_____

ID #:_____**GROUP NAME:**_____ **GROUP #:**_____

NAME OF INSURED:_____**SOCIAL SECURITY#:**_____

RELATIONSHIP TO INSURED:_____**EFFECTIVE DATE:**_____

AUTHORIZATION TO PAY BENEFITS

FOR PRIVATE/COMMERICAL CARRIER ASSIGNMENT OF BENEFITS AND INFORMATION RELEASE:
I, the undersigned, authorize payment of medical benefits to Columbia Urological Associates for any services furnished to me. I understand that I am financially responsible for any amount not covered by my insurance. I also authorize you to release to my insurance company information concerning health care, advice, treatment or supplies provided to me. I further authorize release of this information to other providers as necessary for continuation of care, including radiologists, physicians, and reference labs used when specimens are sent to outside facilities. I permit a copy of this authorization to be used in place of the original.

Date: _____ Signed: _____

MEDICARE LIFETIME SIGNATURE ON FILE:
I, the undersigned, request the payment of authorized Medicare benefits be made on my behalf to Columbia Urological Associates for any services furnished to me by the physician. I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agent, any information needed to determine benefits payable for services.

Date: _____ Signed: _____

PAYMENT AGREEMENT

It is the policy of Columbia Urological Associates, P.A. that charges for services rendered by our physicians and staff be paid for at the time of service unless complete insurance information and authorization for filing is provided to us at your first visit. This information must be accompanied by a copy of your health insurance card(s). You will be responsible for all deductible, co-insurance, or co-pay amounts at the time of service. A claim will be filed for the balance to your insurance company. Please remember that your insurance plan is a contract between you and your carrier; we file claims only as a courtesy to you. If payment has not been made by your insurance carrier(s) within 45 days, the balance will become your responsibility.

If you do not have insurance coverage, payment is expected in full at the time of service. However, if you require any treatment or procedure which is over $100.00, financial arrangements must be made with our business office staff. A minimum payment of 50% of total charges is expected when services are received, and the balance may be made in monthly payments of a mutually agreed upon amount. The balance may not be extended for longer than one year. Any patient account which becomes delinquent (monthly payment not made within 30 days of last payment) will be processed in the collection department of Columbia Urological for appropriate action and patient will be responsible for any collection fees associated with their delinquent account.

If you are a member of an HMO Plan that requires pre-authorization or a referral form for services rendered at Columbia Urological Associates, remember that it is your responsibility to obtain authorization from primary care physician. If you fail to do so, payment for services received will be your financial responsibility.

I agree to the above financial agreement for any services provided to me by Columbia Urological Associates, P.A.

Date:_____ Responsible Party Signature:_____