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Patient's Social Security # Age:	Title: Dr Mrs Mr Ms	
Patient's Last Name First	MI	
Address	_ City State Zip	
Home Phone # () Work Phone # ()	Cell Phone # ()	
Date of Birth: Gender	F Marital Status:	
Race: (please circle) American Indian Asian Af	rican American White Other:	
Ethnicity: (please circle) Hispanic Non-Hispanic		
Language: (please circle) Arabic Chinese English Free	nch Hindi Japanese Spanish	
Email:	Preferred Language:	
Name of Employer	Phone () Ext	
Spouse Employer	Phone () Ext	
Primary Physician Refer		
Emergency Contact Phone	e # () Relationship	
Emergency Contact Phone Name of Person/Guardian responsible for this Bill	e # () Relationship	
Name of Person/Guardian responsible for this Bill	e # () Relationship MI	
Name of Person/Guardian responsible for this Bill Last Name First		
Name of Person/Guardian responsible for this Bill Last Name First	rth:\	
Name of Person/Guardian responsible for this Bill Last Name First Social Security # - Date of Bill Address	MI rth:\ City State Zip	
Name of Person/Guardian responsible for this Bill Last Name First Social Security # Date of Bill	MI rth: \ City State Zip	
Name of Person/Guardian responsible for this Bill Last Name First Social Security # Address Phone # ()	MI rth:\ City State Zip ID#	
Name of Person/Guardian responsible for this Bill Last Name First Social Security # Address Phone # () Relationship to Patient Insurance #1	MI rth: \ City State Zip ID# Subscriber Social Security #	
Name of Person/Guardian responsible for this Bill Last Name First Social Security # Address Phone # () Relationship to Patient Insurance #1	MI	
Name of Person/Guardian responsible for this Bill Last Name First Social Security # Address Phone # () Relationship to Patient Insurance #1	MI rth: \	
Name of Person/Guardian responsible for this Bill Last Name First Social Security # - Date of Bill Address Date of Bill Address Phone # () Relationship to Patient Insurance #1 Subscriber Name Subscriber's DOB Insurance #2	MI rth: \ City State Zip ID#	

Please allow the receptionist to copy all insurance cards and picture ID after completion of paperwork <u>Consent for Treatment</u>

The undersigned authorizes the physician assigned to furnish medical and/or surgical treatment of those means he/she considers necessary and proper in the treatment of the patient identified below while a patient of Gainesville Urology. This treatment may require diagnostic procedures including but not limited to, laboratory testing, blood drawing for those test(s), CT Scans, Ultrasound, Urodynamics, etc.



Financial Aggreement

For services rendered to the patient named below, I, the undersigned, agree to pay all professional and/or outpatient charges not covered by insurance. This includes any co-payments, co-insurance and deductibles that may be owed. I also agree to pay reasonable attorney and/or collection fees necessary for the collection of payment.

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Patient and /or Guardian Signature	Date

Authorization to Release Medical Information and payment of Insurance Benefits

I hereby authorize Gainesville Urology or my attending physician to release or disclose to insurance companies and/or outpatient benefits programs information from my medical record pertaining to my treatment as needed to process insurance claims. Furthermore, I hereby assign payment directly to Gainesville Urology benefits wherein specified and otherwise payable to me but not to exceed Gainesville Urology regular charges for medical treatment. I understand that I am financially responsible for charges not covered by this authorization.

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Patient and /or Guardian Signature	Date

Statement to Permit Payment of Medicare Benefits to Physician (Medicare Patients Only)

I certify that the information given by me in applying for payments under the Title XVII of the Social Security Administration or it intermediaries or carriers is the correct information needed for Medicare claims. I request that payment of authorized benefits be made on my behalf. I assign the benefits payment for physician services to the physician or organization furnishing the services, and authorize such physician or organization to submit claims to Medicare for payment.

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Patient and /or Guardian Signature	Date

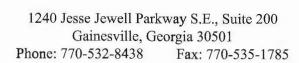
Prescription Refills

Telephone prescription refills must be requested on Monday – Friday between the hours of 8:30 am and 4:00 pm. Please allow 24 – 48 hours for your prescription to be called in. Telephone prescription refills may be delayed due to necessity for the physician to review your record and determine the appropriate medicine to prescribe. Also, please note that it is our belief that narcotic pain relievers are, in general, for short-term use only. Likewise, prescriptions will not be called in after hours and on weekends.

Patient and /or Guardian Signature

Return Phone Calls

The clinic staff at Gainesville Urology will return patient phone calls received before 4:30 pm Monday through Friday before the clinic closes that day. Calls after this time will be returned the next business day. If you believe your medical situation is urgent in nature, please proceed to a hospital emergency room for immediate treatment.



Date
