Gainesville Urology

1240 Jesse Jewell Parkway S.E., Suite 200
Gainesville, Georgia 30501
Phone: 770-532-8438 Fax: 770-535-1785

PLEASE PRINT

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 _____M _____F Marital Status: _____

Race: (please circle) American Indian Asian African American White Other: _____

Ethnicity: (please circle) Hispanic Non-Hispanic

Language: (please circle) Arabic Chinese English French Hindi Japanese Spanish

Email: _____ Preferred Language: _____

Name of Employer _____ Phone (____) _____ Ext. _____

Spouse Employer _____ Phone (____) _____ Ext. _____

Primary Physician _____Referring Physician _____

Emergency Contact _____ Phone # (____) _____ Relationship _____

Name of Person/Guardian responsible for this Bill

Last Name _____ First _____ MI _____

Social Security # ____-____-____ Date of Birth: ____________

Address _____ City_____ State _____ Zip _____

Phone # (____) _____ Relationship to Patient _____

Insurance #1 _____ ID# _____

Subscriber Name _____ Subscriber Social Security # ____-____-____

Subscriber's DOB _____ Relationship to Patient _____

Insurance #2 _____ ID# _____

Subscriber Name _____ Subscriber Social Security # ____-____-____

Subscriber's DOB _____ Relationship to Patient _____

Please allow the receptionist to copy all insurance cards and picture ID after completion of paperwork

Consent for Treatment

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.

_____ _____

Patient and /or Guardian Signature Date

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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.**

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.

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.

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 _____ Date _____

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.

Patient and /or Guardian Signature _____ Date _____