

SOMERSET UROLOGICAL ASSOCIATES

Failure to complete this form legibly and in full may result in your insurance company denying your claim, making you personally responsible for payment of medical services rendered in this office.

Referred By: \_\_\_\_\_

PLEASE PRINT CLEARLY

Pharmacy: \_\_\_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initl. \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Social Security \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_ Sex \_\_\_\_\_ Marital Status \_\_\_\_\_ Spouse Name (if any) \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Allergies \_\_\_\_\_

**Billing:** Please complete if person responsible for bill is OTHER than the above patient

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initl. \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Date of Birth \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_ Social Security \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

**Insurance:** Please supply all information from each insurance policy. If your coverage is contingent on a referral from your primary doctor, a second opinion or a pre-admission approval, it is YOUR RESPONSIBILITY to inform us.

Prim Insurance \_\_\_\_\_ Sec Insurance \_\_\_\_\_

Policy Holder \_\_\_\_\_ Policy Holder \_\_\_\_\_

Policy Holder Date of Birth \_\_\_\_\_ Relationship to Patient \_\_\_\_\_ Policy Holder Date of Birth \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

ID# \_\_\_\_\_ Group# \_\_\_\_\_ ID# \_\_\_\_\_ Group# \_\_\_\_\_

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Somerset Urological Associates for any services provided me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services. I hereby authorize Medicare to furnish to the above named practice any information regarding my Medicare claims under title XVIII of the Social Security Act. I understand that there is a \$25.00 fee charged to all patients who do not cancel/reschedule their appointment within 24 hours prior to the scheduled time. This fee is non-refundable and is charged directly to the patient/responsible party (not your insurance company).

**Medicare signature only:** \_\_\_\_\_ **Date:** \_\_\_\_\_

I hereby authorize release of information necessary to file a claim with my insurance company and assign benefits otherwise payable to me to the doctor or group indicated on the claim. I understand I am financially responsible for any balance not covered by my Insurance Carrier. In the event of no insurance coverage or a lapse in coverage, I understand I am financially responsible for any or all charges rendered by Somerset Urological Associates, P.A. in relation to my care. I understand that there is a \$25.00 fee charged to all patients who do not cancel/reschedule their appointment within 24 hours prior to the scheduled time. This fee is non-refundable and is charged directly to the patient/responsible party (not your insurance company).

**Patient/Responsible Party Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**I hereby give permission for Somerset Urological Associates, P.A. to discuss my medical condition with the following people:**

- 1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

Signature of Patient or Patient Representative: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Representative Relationship: \_\_\_\_\_