SUBURBAN UROLOGY ASSOCIATES

Please Print

PATIENT INFORMATION

Patient Name: _____ Birth date: _____
Last First M.I.

Address: _____ Age: _____
Street

_____
City State Zip

SS# _____ Sex _____ Marital Status _____

Home Ph. # _____ Cell Ph. # _____

Occupation: _____ Work Ph. # _____

Employer Name & Address _____

Name of Insurance Co: _____

Name of Insured: _____

Birthdate of Insured: _____

Please show your latest insurance card to the receptionist

PRIMARY CARE PHYSICIAN INFORMATION

Name of Primary Care Physician: _____

Address: _____

Phone #: _____

Referring Physician: _____

OTHER INFORMATION

Spouse Name: _____ Spouse Employer _____

Work Phone: _____ Cell Phone _____

In Case of Emergency, Contact (*not at same address*)

Name: _____ Relationship: _____

Phone #: _____

IMPORTANT: *All charges and/or co-payments are due at time of service*

Insurance Authorization and Assignments: I request that payment of authorized benefits be made in my behalf to Suburban Urological Associates for any services furnished me by the physician. I authorize release of any medical information necessary to process my claims. I understand that I am responsible for all charges regardless of insurance coverage. In Medicare assigned cases, the physician agrees to accept the charge determination of the Medicare carrier as the full charge and the patient is responsible only for the deductible, co-insurance, and non covered services.

Patient Signature: _____ Date: _____

Updated _____ Initials _____

Suburban Urologic Associates

FINANCIAL POLICY

Thank you for choosing our office as your health care provider. The following is a statement of our financial policy, which we require that you read and sign prior to any treatment.

INSURANCE

Your insurance policy is a contract between you and your insurance company. We will submit medical services to your insurance company if you have given us all of the required information. We must have the most current copy of your insurance card**.** You must notify us immediately of any change in your insurance coverage. Please be aware that some, and perhaps all, of the services provided may be considered "non-covered services" according to your policy. You will still be responsible for payment of these services. You are also responsible for obtaining the necessary referrals from your PCP and/or insurance company if applicable. However, authorization from your insurance company does not guarantee payment.

We are participating with most major insurance companies. Please check with your insurance company to determine if we are participating providers. We will collect the current co-payment required for a specialist office at the time of service. All patients are responsible for presenting the most current information and paying the most current specialist co-pay. **COPAY WILL BE COLLECTED AT REGISTRATION. YOUR APPOINTMENT MAY BE RESCHEDULED FOR NONPAYMENT OF COPAY. YOU WILL ALSO BE RESPONSIBLE FOR PAYMENT OF ANY DEDUCTIBLE, CO-INSURANCE, OR NON-COVERED SERVICE AT THE TIME OF REGISTRATION.**

Deductible and co-insurance responsibilities for procedures/surgeries will be determined and collected prior to the service. In this instance, our Billing Department will discuss this with you. These amounts must be paid in full or the procedure/surgery will be rescheduled.

BILLING

If you have financial problems, please ask to discuss a payment plan with our Billing Department (proof of income may be required as verification). A billing statement of medical services received will be mailed to you on a monthly basis. If an extended payment plan has been offered to you, we require regular payments or the plan is void. After that, the account may be turned over to our collection agency and a fee will be assessed. We accept cash, checks, Visa, MasterCard or Discover for payment. In the event that a personal check is returned unpaid from your bank for any reason, your account will be charged with a return check fee.

OTHER INSURANCE FORM PREPARATION

If you have insurance forms that need to be prepared by our office (i.e. disability, FMLA), we will do these as quickly as possible but they may take several days for completion.

A fee will be assessed and collected prior to completion of these forms. Please provide us with the correct address for the forms' return.

COLLECTION BALANCES

All collection balances transferred to an outside collection agency, will be assessed a collection fee. If you have had a previous collection balance or are presently in collection, it will be required that you pay your previous balance **IN FULL** prior to being seen again.

CANCELLATION POLICY

Please help us provide better service by keeping your scheduled appointment. Notify us at least 24 hours in advance if you are unable to keep your scheduled appointment. Repeated failure to keep appointments may jeopardize your next visit to our office and a fee may be assessed. There is a $100 Cancellation/No Show fee for select procedures and surgeries. Our scheduling department will review this with you when the procedure/surgery is scheduled.

MEDICAL RECORDS RELEASE

Please contact our office if it becomes necessary for you to obtain a copy of your medical records. We have a standard records release form that must be completed and signed by the patient. An administrative fee may be assessed for this process.

I have read the above financial policy. I understand and agree to this financial policy.

_____ _____

Signature of Patient or Responsible Party Date

_____

Print Name

SUBURBAN UROLOGIC ASSOCIATES

PATIENT PHARMACY INFORMATION

Today's Date: _____

Patient Name: _____ Birth Date: _____

Name of **Retail** Pharmacy: _____

Street: _____

City: _____

Phone Number: _____

Name of **Mail Order** Pharmacy: _____

If Medco, please list your Medco ID Number: _____