

Valley Urology Patient Information

Date: _____

Patient Name: _____ Sex: M F
(Last) (First) (M.I.)

Mailing Address: _____ City: _____ State: _____ Zip: _____

Physical Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ SSN#: _____ Marital Status: S M

Telephone (home): _____ (work): _____ (cellular): _____ (message): _____

Patient (Parent's) Employer: _____ Occupation: _____

Spouse (Parent's) Name: _____ Phone: _____

Emergency Contact: _____ Phone: _____

Referred by: _____ Primary Care Physician: _____

Insurance Information

PRIMARY INSURANCE COMPANY NAME	SECONDARY INSURANCE COMPANY NAME
INSURANCE COMPANY'S ADDRESS	INSURANCE COMPANY'S ADDRESS
CITY STATE ZIP	CITY STATE ZIP
INSURED'S NAME INSURED'S DATE OF BIRTH	INSURED'S NAME INSURED'S DATE OF BIRTH
INSURED'S EMPLOYER INSURED'S SSN	INSURED'S EMPLOYER INSURED'S SSN
INSURED'S ID NUMBER GROUP PLAN NUMBER	INSURED'S ID NUMBER GROUP PLAN NUMBER
RELATIONSHIP TO INSURED	RELATIONSHIP TO INSURED
SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER <input type="checkbox"/>	SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER <input type="checkbox"/>

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Valley Urology

FINANCIAL POLICY:

An understanding of our financial policy is important in our professional relationship.

It is your responsibility to provide us with the information we require in order to bill your insurance carrier **(which includes the insured's name, address, date of birth and social security number)**. We will submit your charges to your insurance company as a courtesy. Failure to provide the information requested will require payment at the time of service, you will be provided a receipt for your services, and you may submit the claim to your insurance carrier for reimbursement.

You will be responsible for the amount your insurance does not pay. **If you have not met your yearly deductible, and/or have a percentage or portion that you are normally responsible for, expect to pay this portion at the time of service.**

If you have insurance and undergo surgery, we will file your insurance claims on your behalf. The patient is ultimately responsible for any preauthorization requested by the insurance company for clinic visits and/or surgical procedures.

PATIENT CONSENT/AGREEMENT:

I hereby authorize the processing of the medical insurance either by electronic or manual method.

I agree to full responsibility for all expenses incurred for medical treatment including any co-payments, charges applied to my deductible, non-covered charges, or any fees found to be in excess of the "usual and customary" rate of my insurance carrier.

I further authorize Valley Urology to release all medical and/or insurance claim information necessary to secure payment. I hereby authorize payment directly to Valley Urology/Greg O. Lund, MD for services rendered to me or a member of my family.

This agreement will remain in effect until revoked by me in writing. A copy of this document is considered as valid as the original.

Signature

Date