

Valley Urology
 2490 S. Woodworth Loop, Suite 401
 Palmer, Alaska 99645
 (907) 745-9300 Phone
 (907) 745-9301 Fax

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 D W

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

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

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

Emergency Contact: _____ Phone: _____

Referred by: _____

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 EMPLOYER
INSURED'S ID NUMBER GROUP PLAN NUMBER	INSURED'S ID NUMBER GROUP PLAN NUMBER
RELATIONSHIP TO INSURED	RELATIONSHIP TO INSURED
SELF SPOUSE CHILD OTHER	SELF SPOUSE CHILD OTHER

CONTINUED ON BACK

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FINANCIAL POLICY:

An understanding of our financial policy is important in our professional relationship. Payment is requested at the time of service for office visits. If you have given us the appropriate information, we will submit your charges to your insurance company as a courtesy. 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