

CENTRAL TEXAS UROLOGY

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ALL SERVICES, WHEN APPROPRIATE, ARE DUE AND PAYABLE AT THE TIME OF SERVICE.

PATIENT INFORMATION

Date _____

Patient Name _____ Birthdate _____ Age _____
Last First Middle

Address _____ City _____ State _____ Zip _____

Home Phone _____ Male Female SSN _____ Driver License# _____

Cell Phone _____ Check Appropriate Box: Minor Single Married Divorced Widowed Separated

Employer _____ Work Phone _____

Business Address _____ City _____ State _____ Zip _____

Guardian/Spouse's Name _____ Birthdate _____ Age _____

SSN ____/____/____ Employer _____ Work Phone _____

Alternate Emergency Contact _____ Relationship _____ Phone _____

Referring Physician _____ Family Physician _____

Please list any allergies _____

I authorize release of medical information to be given to: _____ Relationship to patient _____

Is this visit related to a Workman's Compensation Insurance Claim? Yes No

Primary Ins. Co. _____ Name of Insured _____

Sec. Ins. Co. _____ Name of Insured _____

PATIENT ACKNOWLEDGEMENT (please initial each statement)

_____ I authorize direct payment of medical benefits to Central Texas Urologic Associates, P.A. for services furnished to me.

_____ I permit a copy of this authorization to be used in place of the original.

_____ I certify the above information is true and correct and realize that I am financially responsible for all medical bills.

_____ A Notice of Privacy Practices describing my rights under HIPAA Law and the uses & disclosures of my protected health information has been made available to me.

_____ I consent to the use & disclosure of protected health information about me for the purposes of treatment, payment & health care operations.

Patient Signature _____ Date _____