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NEW PATIENT INFORMATION

Name:_____ Date of Birth:_____

Street/P.O. Box:_____ Sex: ☐Male ☐Female

City, State, Zip:_____

Home #:_____ Cell #: _____ SS#:_____

Place of Employment:_____ Retired From:_____

Is this visit for a work-related injury? ☐Yes ☐No **(IF YES TELL THE RECEPTIONIST)**

Spouse or Legal Guardians Name: _____ Relationship:_____

Referring Physician:_____ Family Physician:_____

Pharmacy:_____

Emergency Contact:_____ Phone:_____

PATIENT'S INSURANCE INFORMATION NOTE: PATIENTS ARE RESPONSIBLE FOR VERIFYING THEIR BENEFITS AND GETTING PRECERTIFICATION INFORMATION TO OUR OFFICE. WE WILL BE HAPPY TO PRECERT IF INFORMATION IS COMPLETE. (IF YOUR INSURANCE REQUIRES A REFERRAL THIS NEEDS DONE BY YOUR PRIMARY CARE PHYSICIAN PRIOR TO BEING SEEN. YOU WILL BE RESPONSIBLE FOR VISIT'S TOTAL CHARGE IF THERE IS NOT A REQUIRED REFERRAL ON FILE WITH YOUR INSURANCE COMPANY)

PLEASE GIVE A COPY OF ALL OF YOUR INSURANCE CARDS TO THE FRONT DESK CLERK PRIOR TO BEING SEEN.

INSURANCE AUTHORIZATION AND ASSIGNMENT

NAME OF POLICY HOLDER:_____

I request that payment of authorized Medicare/Commercial Insurance company benefits be made to **N.E.O. Urology Associates, Inc.** for any services furnished me by that party who accepts assignment/physician. Regulations pertaining to Medicare assignment of benefits apply.

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information for this or a related Medicare Claim/Other Insurance Company Claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and 21 U.S.C. 3801-3812 provides penalties for withholding this information.) I understand that I am financially responsible for all charges and services rendered. Further, I permit a copy of this authorization to be used in place of the original.

Signature:_____ **Date:**_____