N.E.O. Urology

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NEW PATIENT INFORMATION

Name: _____ Birth Date: _____

Address: _____ Sex: ___ Male ___ Female

City, State, Zip: _____

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

Employed by: _____

Is this visit for a work-related injury? ___Yes (if yes, tell the receptionist now) ___ No

Spouse or Legal Guardians Name: _____ Relationship: _____

Referring Physician: _____ Family Physician: _____

Pharmacy and Location: _____

Emergency Contact: _____ Phone: _____

Patient's Insurance Information Note: *Patients are responsible for verifying their benefits and getting pre-certification information to our office. If your insurance requires a referral, this needs to be done by your Primary Care Physician prior to being seen. You will be responsible for total charge if there is not a required referral on file with your insurance company.*

Bring all of your insurance cards to the receptionist when you take up the completed paperwork.

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. 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: _____