Pensacola Urology, P.A.

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Patient Number ____________________

Referring Physician ____________________

Pharmacy ____________________

Pharmacy Number ____________________

PATIENT INFORMATION

(PLEASE PRINT AND COMPLETE ALL INFORMATION)

Last Name ______________ First Name ______________ Middle Name ______________

Home Phone ______________ Work Phone ______________ Cell Phone ______________

Mailing Address ______________________________ DOB ______________

City ______________ State ______ Zip ______ Sex: ☐ M ☐ F Age ______

Marital Status: ☐ Single ☐ Divorced ☐ Married ☐ Widow ☐ Separated Spouse Name ______________

Patient's Place of Employment ______________________________

Retired?: ☐ Yes ☐ No **Patient's Social Security Number** ______________

Person responsible for payment ______________________________

Mailing Address of responsible party ______________________________

Medicines to which you are allergic ______________________________

INSURANCE INFORMATION (INCLUDING MEDICARE)

PRIMARY Insurance ______________________________

Group # ______________ Policy # ______________

Policy Holder's Name ______________ SSN ______________ DOB ______________

Parent's' name if patient is child ______________________________

Spouse's / Parent's Place of Employment ______________ Work Phone ______________ Retired?: ☐ Yes ☐ No

SECONDARY Insurance ______________________________

Group # ______________ Policy # ______________

Policy Holder ______________ Relationship to Patient ______________

If this is Group Insurance, name of Employer ______________________________

RELEASE OF INFORMATION / ASSIGNMENT OF BENEFITS

- Release of Information: The physician may disclose all or any part of the patient's records to any person or corporation which is, or may be, liable under contract to the physician or the patient or to a family member or employer of the patient, for all or part of the physician's charge, including, but not limited to, insurance companies, workers compensation carriers, and welfare funds. The physician may also send copies of all or part of the patient's records to any physician that participates in the total medical care of the patient.
- Assignment of Insurance Benefits: In the event the patient is entitled to physician benefits arising out of any policy of insurance insuring patient or any other party liable to patient, said benefits are hereby assigned to the physician for application on patient's bill, and it is agreed the physician upon receipt of such benefits, shall discharge the said insurance company of any and all obligations under the policy to the extent of such payment and the undersigned and/or patient shall be responsible for all charges not covered by this assignment.
- Medicare / Medicaid Patients Certification: I certify that the information given by me in applying for payment under Titles XVIII and XIX of the Social Security Act is correct. I authorize the release of all my records required to act on this request and that payment of authorized benefits be made directly to the physicians involved in my care and for any services furnished to me requested by said physicians.

______________________________ ______________________________

Patient / Patient's Representative, if patient is unable to sign Date Relationship

______________________________ ______________________________

Patient / Patient's Representative, if patient is unable to sign Date Relationship

______________________________ ______________________________

Patient / Patient's Representative, if patient is unable to sign Date Relationship

PENSACOLA UROLOGY, PA
PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent to Pensacola Urology, PA to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Pensacola Urology's Notice of Privacy Practices provides a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Pensacola Urology reserves the right to revise its Notice of Privacy Practices at anytime. A Notice of Privacy Practices may be obtained by forwarding a written request to Pensacola Urology's Privacy Officer at **1717 North "E" Street, Suite 430 Pensacola, FL 32501.**

With this consent, Pensacola Urology may use the following means to contact me regarding any items that assist the practice in carrying out TPO, such as appointment reminders, insurance information, billing statements, or any calls pertaining to my clinical care, including laboratory results among others: calling my home or other alternative location and leaving a message on voice mail; e-mailing my home or other alternative location; sending written mail to my home or other alternative location as long as it is marked "Personal and Confidential."

I wish to be contacted in the following manner (check all that apply).

- ❑ Home Telephone ____________________
  - ❑ O.K. to leave message with detailed information
  - ❑ Leave message with doctor's name and phone number only
- ❑ Work Telephone ______________________
  - ❑ O.K. to leave message with detailed information
  - ❑ Leave message with call-back number only
- ❑ Written Communication
  - ❑ O.K. to mail to my home address
  - ❑ O.K. to mail my work/office address
  - ❑ O.K. to e-mail me at this address _______________
  - ❑ O.K. to fax to this number ______________________
- ❑ Other ____

I have the right to request that Pensacola Urology restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to Pensacola Urology's use and disclosure of my PHI to carry out TPO.

Pensacola Urology, PA may disclose my PHI to the following individuals:

Name	Relationship	Telephone

I may revoke my consent in writing except to the extent that the practice has already made disclosures based upon my prior consent. If I do not sign this consent, or later revoke it, Pensacola Urology may decline to provide treatment to me.

Assignment of Insurance Benefits: In the event the patient is entitled to physician benefits arising out of any policy of insurance insuring patient or any other party liable to patient, said benefits are hereby assigned to the physician for application on patient's bill, and it is agreed the physician, upon receipt of such benefits, shall discharge the said insurance company of any and all obligations under the policy to the extent of such payment and the undersigned or patient shall be responsible for all charges not covered by this assignment.

Medicare/Medicaid Patients Certification: I certify that the information given by me in applying for payment under Titles XVII and XIX of the Social Security Act is correct. I authorize the release of all my records required to act on this request and that payment of authorized benefits be made directly to the physicians involved in my care and for any services furnished to me requested by said physician.

______________________________________ Signature of Patient or Legal Guardian

______________________________________ Date

______________________________________ Print Name of Patient or Legal Guardian