Urodocs
Modern Compassionate Urology

Patients Name: **Today's Date: / /**

Date of Birth: ____/___/_____ Age: _____ Sex: M or F (decline)

Social Security #: _____/____/_____ Marital Status: Single or Married or Divorced

Permanent Address: _____

_____

EMAIL (for portal access and communications): _____

TEL: _____ _____ _____

(Home Phone) **(Cell Phone)** **(Other Phone)**

Emergency Contact: Name: _____ Phone #: _____

Health Care Surrogate : Name: _____ ***Phone #:*** _____

Employment Information:

Employer Name: _____ Phone Number: _____

Medical Provider Information:

Referring Physician: _____ Phone #: _____ Fax#: _____

Family Physician: _____ Phone #: _____ Fax#: _____

Preferred Pharmacy:_____

Address: _____ , City_____

Phone #: _____ Fax#: _____

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Have you seen a Urologist before? , **if yes, name of your prior Urologist**: _____

MEDICAL / INSURANCE INFORMATION:

Primary Insurance: _____ Secondary Insurance: _____

Policy Number: _____ Policy Number: _____

Insured Member: _____ Insured Member: _____

Group Number: _____ Group Number: _____

Disclaimer: I fully understand that I am directly and fully responsible, and guarantee payment, for all medical bills and payment to Urodocs. for services rendered. This agreement is made solely for Urodocs and Dr. Levin's protection. I understand that payment is not contingent upon any settlement nor judgment nor insurance payment by which I may eventually recover said fee. I agree to an interest of 2 % to charges over 60 days late. I agree to pay for all professional fees associated with collecting my outstanding balances. I agree to allow Urodocs to use a credit card I maintain on file for payments due.

Authorization to pay benefits to Physician: I hereby authorize payment directly to the undersigned Physician of the medical / surgical benefits, if any, otherwise payable to me for his services as described, but not to exceed reasonable and customary charges for said services. I understand that I am fully financially responsible for charges not covered by this authorization. I understand that payment is not contingent upon any settlement nor judgment nor insurance payment by which I may eventually recover said fee. I understand that information may need to be released to other parties, such as insurance agencies and /or Medicare, to facilitate payment. I understand that records may also be sent to my other physicians and family members, unless I instruct Dr. Levin otherwise.

Policy: We strive to see all patients on time. When patients show up late or do not call ahead to reschedule it has an affect an all our other patients, Therefore, please be advised, if you do not cancel or reschedule your appointment at least 2 working days prior to your scheduled time, you may be charged **a $ 75.00 no show fee, at our discretion**. Certainly we will make every effort to accommodate your needs. We also must address emergencies as they present and will give you or any patient extra time when needed. Your understanding is appreciated in these circumstances.
I am aware and understand the policy of this practice.
By signing this page I attest that all the information I am providing to the office of Dr. Levin is true and accurate.

(Name) _____ (Date) : _____/_____ / _____

Responsible persons Signature): _____

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