Urology Care Alliance

Patient Demographics

First Name ____________________ MI _____ Last Name __________________________

Date of Birth ___________ Age______

Social Security Number ______-_____-_______

Gender: Male _____ Female _____ T/G ______

Address ____

City_______________ State_____ Zip_________

Primary Phone #__________________________ Cell Phone #________________________

Work Phone # ________________________ E-Mail Address ________________________

Marital Status: ☐Single ☐Married ☐ Separated ☐ Divorced ☐Widowed

Ethnicity: ☐Caucasian ☐African American ☐Hispanic Origin ☐Other ☐Decline

If other than English, what is your primary language _______________________

Employer______________________________________ Occupation_________________

How did you hear about us? ☐Primary Care Physician ☐Other____________________

Medical Information

Referring Physician: Name________________________________

Address___________________________City_______________State_____Zip_________

Office Phone_________________________________

Primary Care Physician Name__________________________________

Address___________________________City_______________State_____Zip_________

Office Phone_________________________________

Pharmacy Information

Pharmacy Name _____________________________Pharmacy Phone________________

Mail Order Pharmacy __________________________________

Urology Care Alliance

Insurance Information

Primary Insurance

Name____

Policy ID #______________________________ Group # ____________________

Subscriber's Name______________________ Subscriber's Date of Birth__________

Relationship to Patient: Self Spouse Child Other________________

Secondary Insurance

Name____

Policy ID #______________________________ Group # ____________________

Subscriber's Name______________________ Subscriber's Date of Birth__________

Relationship to Patient: Self Spouse Child Other ________________

Emergency Contact Information

Name____Relationship_____________

Primary Phone #______________________ Cell Phone #______________________

Privacy Information

Approve method for leaving detailed messages:

	Appointment Information	Medical Information
On home phone number	☐Yes ☐ No	☐Yes ☐ No
On cell phone number	☐Yes ☐ No	☐Yes ☐ No
On work voicemail	☐Yes ☐ No	☐Yes ☐ No
With another person	☐Yes ☐ No	☐Yes ☐ No
Send via US mail	☐Yes ☐ No	☐Yes ☐ No
Send via Patient Portal	☐Yes ☐ No	☐Yes ☐ No

Email address: ____

*If you answered **YES** to allowing us to discuss your appointment or medical information with another person please list their name, relationship and phone #. They must be added to the HIPAA authorization list.*

Name	Relationship	Primary Phone#	Cell Phone#

Urology Care Alliance

Patient Name__________________________________ Date of Birth ______________

Financial Policy

I hereby authorize payment directly to Premier Urology Associates LLC (dba Urology Care Alliance here after referred to as UCA) for surgical or medical services rendered. I shall be personally liable for any unpaid balance to the company. We must emphasize that as a medical provider our relationship is with you and not your insurance carrier. While filing claims is a courtesy that we extend to our patients; all charges are your responsibility from the date services are rendered. We request that if you participate in any HMO, PPO, or Managed Health Care plans, that you bring this to the attention of our staff in regards to authorizations or restrictions that may apply for medical care, lab work and surgery scheduling.

I authorize direct payment to the above entities from the listed companies. I understand that I am responsible for obtaining referrals, if necessary, and paying co-payments, coinsurance, or deductible amounts required by my plan. I understand that I may be responsible for the full amount in the event of non-coverage determined by my plan.

Initials________ There will be a $25 charge for appointments not cancelled within 24 hours.

Medical Release

I hereby authorize UCA to release necessary medical information to my insurance company(ies). I further authorize the release of medical information including diagnosis and records of any treatment or examination rendered to me by UCA to any physician or my insurance carrier. I authorize the release of medical information from any other medical facility or physician mailed or faxed to UCA for help in my care and treatment.

Initials_______

Authorizations

I certify that I am the patient or duly authorized agent of the patient and authorize to furnish the information requested. All information provided is current and accurate to my knowledge. I have read the above Medical Policy, I understand it, and agree to the terms that are listed.

Signature: ______________________________________ Date____________________