UROLOGIC SPECIALISTS OF NEW ENGLAND

PATIENT INFORMATION

NAME: _____ HOME PHONE:( )_____ CELL PHONE:( )_____
FIRST MIDDLE LAST

STREET ADDRESS: _____ EMAIL ADDRESS:_____

CITY: _____ STATE:_____ ZIP: _____ DATE OF BIRTH: _____

SEX: _____ MARITAL STATUS: _____ SOCIAL SECURITY #: _____

DRIVERS LICENSE #: _____ CLOSEST RELATIVE NOT LIVING WITH YOU: _____

RELATIONSHIP TO PATIENT: _____

HOME PHONE: ( )_____ WORK PHONE: ( )_____

ADDRESS: _____

PRIMARY CARE PHYSICIAN (PCP)_____

REFERRING PHYSICIAN (IF DIFFERENT FROM PCP): _____

EMPLOYMENT INFORMATION

EMPLOYER: _____ WORK PHONE: ( ) _____

ADDRESS: _____ POSITION: _____

CITY: _____ STATE: _____ ZIP:_____

INSURANCE INFORMATION

PRIMARY INSURANCE: _____ **INSURANCE ID #:**_____

NAME OF POLICY HOLDER: _____

POLICY HOLDER'S DATE OF BIRTH: _____ POLICY HOLDER'S SSN: _____

POLICY HOLDER'S EMPLOYER: _____

COPAY AMOUNT: _____

SECONDARY INSURANCE: _____ **INSURANCE ID#:** _____

NAME OF POLICY HOLDER: _____

POLICY HOLDER'S DATE OF BIRTH: _____

POLICY HOLDER'S EMPLOYER: _____

COPAY AMOUNT: _____

I authorize release of information to file a claim with my insurance company and to assign benefits to Rhode Island Urological Specialties. I understand that I am financially responsible for any unpaid balance and that a late fee of 1.5% per month will be assessed on all balances over 30 days.

SIGNATURE: _____ **DATE:** _____

Please provide additional information on back if applicable.

1) Are you seeking treatment for an injury at work? Yes No

If yes, please provide name and address of:

Employer: _____

Attorney: _____

Workers' Compensation Carrier: _____

Name of Adjuster: _____

Date of Injury: _____

File/Claim#: _____

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2) Are you seeking treatment for an automobile-related accident? Yes No

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If yes, please provide name and address of:

Insurance Company: _____

Attorney: _____

Date of Injury: _____

File/Claim#: _____

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3) Is a liability claim involved? Yes No

If yes, please provide name and address of:

Insurance Company: _____

Attorney: _____

Date of Injury: _____

File/Claim#: _____

PATIENT NAME:_____ **DATE:**_____

UROLOGIC SPECIALISTS OF NEW ENGLAND PAYMENT POLICY

We are committed to providing you with the best possible care. If you have medical insurance we will help you receive your maximum allowable benefits. In order to achieve these goals we need your assistance. It is also important you understand our payment policy.

Payment for services is due at the time services are rendered. We accept cash, checks and most major credit cards. Please make sure we have your most up-to-date insurance information when you come to the office. For insurance plans we participate with, we accept assignment of benefits. This means we accept direct payment from your insurer. You are responsible for payment of any applicable co-payments and/or deductibles. Your insurance company will tell you whether or not we participate with it. For insurance plans we do not participate with, we will process and submit the necessary claim forms. You are responsible for payment of the balance of all charges your insurance company does not cover. Many insurance plans require a referral from your primary care physician. This is your responsibility and your appointment may be rescheduled if you do not obtain the necessary authorizations.

Returned checks are subject to a $15 fee while balances older than 30 days will be assessed interest at the rate of 1.5% per month. Charges may also be made for appointments not kept or those canceled without 24 hours advance notice. There will be a minimum charge of $10 for any forms (e.g., medical leave, disability, insurance) that we are asked to complete. Accounts outstanding more than 90 days will be turned over to a collection agency or attorney unless efforts are made with our Billing Department to reconcile any questions or problems. I understand and agree that should any unpaid balance be placed with an attorney for collection I then will be held responsible for attorney's fees in the amount of 33 1/3% of the balance then due.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. Assisting you with the filing of your insurance claims is a courtesy we extend to you. However, not all services are covered benefits and all charges are your responsibility from the date services are rendered. If you have any questions about the above information please don't hesitate to ask. The Billing Department will be happy to assist you.

I HAVE READ AND UNDERSTAND THIS POLICY

PATIENT SIGNATURE:_____
(or representative)