



**PATIENT INFORMATION**

NAME (Last, First Middle)		SSN#	BIRTHDATE	SEX
LOCAL ADDRESS		SECONDARY/BILLING ADDRESS (if Applicable)		
CITY, STATE ZIP		CITY, STATE ZIP		
HOME PHONE		HOME PHONE		
PRIMARY EMPLOYER		SECONDARY EMPLOYER (if Applicable)		
ADDRESS		ADDRESS		
CITY, STATE ZIP		CITY, STATE ZIP		
WORK PHONE		WORK PHONE		

**RESPONSIBLE PARTY INFORMATION (if Different than above)**

NAME (Last, First Middle)		SSN#	BIRTHDATE	SEX
LOCAL ADDRESS		SECONDARY/BILLING ADDRESS (if Applicable)		
CITY, STATE ZIP		CITY, STATE ZIP		
HOME PHONE		HOME PHONE		
RELATIONSHIP TO PATIENT				

**PRIMARY INSURANCE**

NAME OF INSURANCE COMPANY		POLICY#		
NAME OF INSURED		GROUP#		
ADDRESS OF INSURANCE COMPANY		COPAY AMT \$		
CITY, STATE ZIP		DEDUCTIBLE \$		
RELATIONSHIP TO PATIENT		EFFECTIVE DATE	EXPIRATION DATE	

**SECONDARY INSURANCE (if Applicable)**

NAME OF INSURANCE COMPANY		POLICY#		
NAME OF INSURED		GROUP#		
ADDRESS OF INSURANCE COMPANY		COPAY AMT \$		
CITY, STATE ZIP		DEDUCTIBLE \$		
RELATIONSHIP TO PATIENT		EFFECTIVE DATE	EXPIRATION DATE	

ASSIGNMENT OF BENEFITS: I irrevocably assign my right to payment from any insurance company/ other payor of health benefits to Urological Surgical Associates,P.A. for services furnished to me.

RELEASE OF INFORMATION: I understand that USA, P.A. is entitled to release my medical & insurance information to any entity for the purposes of treatment,payment or operational purposes.

RECEIPT OF INFORMATION:I acknowledge that I have received USA, P.A.'s Notice of Privacy Practices and Financial Policy. I have read and understand each of the 3 foregoing paragraphs and my questions have been answered.

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SIGNATURE OF PATIENT/GUARDIAN

\_\_\_\_\_  
DATE