THE UROLOGY GROUP CENTRAL INDIANA

Patient Information:

Full Name: _____ Birthdate: _____ SS#: _____

Address: _____

Home Phone: _____ Cell Phone: _____

Age: _____ Sex: _____ Height: _____ Weight: _____

Marital Status: _____ Email Address: _____

Employer: _____ Occupation: _____ Work Phone: _____

Local family or friend: _____ Phone: _____

Spouse OR Responsible Party Information:

Full Name: _____ Birthdate: _____ Cell Phone: _____

Employer: _____ Occupation: _____ Work Phone: _____

Physician Information:

Primary Care Physician: _____ Preferred Pharmacy: _____

Insurance Information:

Primary: _____ Secondary: _____

Release and Authorization:

I authorize the doctors of The Urology Group Central Indiana and their staff to give reasonable and proper care. I authorize the doctors to give medical information to other healthcare providers. I authorize The Urology Group Central Indiana to release any medical information to my insurance company to file a claim for medical, surgical, and or telemedicine (digital, video, phone calls) services rendered. I request my payments under medical insurance program are assigned directly to the above-named medical group on any services. I understand I am financially responsible for any balance not covered by my insurance (copy of signature is valid as the original). I am responsible financially for health services and payment of claims from my insurance company. In the event of default, reasonable collection agency fees equal 30% of the delinquent balance, reasonable attorney fees and any applicable court costs shall be added to the amount due on the account. By providing my cell phone number, I give prior express consent to receive calls/text messages from a creditor or its third party det collector at the number, including calls and messages made by using an auto-dialer or prerecorded message. I understand part of my urological care may involve surgery at Ball Memorial Surgical Outpatient Center, Lithotropsy Institute of Indiana and or Muncie Laser Service. I understand my urologist have a percentage of ownership in this facility. I understand that I have the option to choose another facility for my care.

Patient/Responsible Party: _____ Date: _____