

CONFIDENTIAL PATIENT INFORMATION

Date: \_\_\_\_\_

Name: (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (MI) \_\_\_\_\_

SS#: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Race: \_\_\_\_\_ Language \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cellular Phone: \_\_\_\_\_

Northern Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Primary Care Name: \_\_\_\_\_ Referred by: \_\_\_\_\_

Email address: \_\_\_\_\_

Permanent Billing Address: \_\_\_\_\_

Florida Address: \_\_\_\_\_

Northern Address: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ SS#: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Emergency Contact Phone: \_\_\_\_\_

**Policy Holder Information: Patient, Parent/Guardian of Child**

Policy Holder Name: \_\_\_\_\_ Policy Holder Phone: \_\_\_\_\_

Policy Holder SS#: \_\_\_\_\_ Policy Holder DOB: \_\_\_\_\_

IF PATIENT IS CHILD, PLEASE COMPLETE THE FOLLOWING:		
Father's Name: _____	Birth Date: _____	SS# _____
Mother's Name: _____	Birth Date: _____	SS# _____

Do you have an Advance Directive: Yes  No

If yes, what type? \_\_\_\_\_

I grant permission to the employees of Bartow HMA, Physicians Management, LLC Group to render care to me and expedite the orders of the physician and/or physician extender. I further authorize release of this information to other healthcare providers associated with my care.

Patient/Parent Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

General Consent to Treat/Patient Authorization/

Acknowledgement of Benefits Release

The following are the conditions for services provided by Bartow HMA Physician Mgmt. LLC for the patient whose name appears at the bottom of this page.

**Consent for Medical Treatment**

I/we voluntarily consent to medical treatment and diagnostic procedures provided by Bartow HMA Physician Mgmt. LLC and its associated physicians, clinicians, and other personnel. I/we consent to the testing for infectious diseases, such as, but not limited to syphilis, AIDS, hepatitis and testing for drugs if deemed advisable by my physician. I/we am/are aware that the practice of medicine and surgery is not an exact science and I/we acknowledge that no guarantees have been made as to the result of treatments or examinations.

**Authorization for Release of Information**

The practice and physicians are authorized to release any medical information required in the processing of applications or submission of information for financial coverage, discharge planning and further medical treatment, to disclose to my employer (if seen for work related exam or injury) insurance and/or any third party payer all medical information, test results and findings made during the course of this examination and/or treatment. To include information referring to psychiatric care, sexual assault or tests for infectious diseases including AIDS/HIV for services provided during this visit. I/we also agree to the release of medical or other information about me to government federal or state regulatory agencies as required by law.

**Assignment of Insurance Benefits**

I/we guarantee payment of all charges made for or on account of the patient and I/we assign our rights in any insurance benefits or other funding to the physician and Bartow HMA Physician Mgmt. LLC. I/we understand that I/we am/are responsible for any charges not covered by insurance or other forms of benefits. I/we understand that Bartow HMA Physician Mgmt. LLC can obtain my/our credit report for review in collection of this debt. In the event this account is placed with a collection agency or attorney for collection or collected, I/we shall pay all collections fees, and cost, including reasonable attorney's fees. For Medicare beneficiaries: I/we provided all necessary information for proper assignment of Medicare benefits.

**Acknowledgement of Receipt of Notice of Privacy Practices**

I/we have received a copy of the Notice of Privacy Practices. The notice describes how my health information may be used or disclosed. I understand that I should read it carefully. I am aware that the Notice may change at any time.

\_\_\_\_\_

Date

\_\_\_\_\_

Signature of Patient/(Parent, Guardian or Legally Authorized Representative)

\_\_\_\_\_

Date

\_\_\_\_\_

Witness

**UroCare**

**Bartow HMA Physician Mgmt. LLC**

**Elite Surgical Associates**

**Financial Policy**

Thank you for choosing Bartow HMA Physician Mgmt. LLC. as your healthcare provider.

We are committed to providing you with the best possible care, and will help you receive your maximum allowable insurance benefits. However, we need your assistance and your understanding of our payment policy. Your insurance contract is between you, your employer and the insurance company. Not all services are covered by all contracts.

Patients who have insurance carrier with whom this practice has a valid contract will be responsible for all fees as outlined in the patient's contract agreement. Insurance is filed for all primary carriers, secondary or supplemental insurance is filed as well. A claim form can be provided at the time of service for the patient to file. Deposits are collected for all procedures over \$250.00. The deposit is to be paid prior to the actual date of the procedure.

Due to current federal and insurance regulations, *all* co-payments, co-insurance and deductibles are collected at time of service. We accept cash or checks, and for your convenience, Visa, MasterCard or Discover. An additional fee of \$25.00, which typically is not covered by insurance plans, will be charged for services such as copying of medical records, and completion of disability forms and/or insurance forms. A fee of \$25.00 will be charged for checks returned for insufficient funds. Delinquent accounts are sent to collections 90 days from the date service was rendered. We encourage you to contact us promptly for assistance in the management of your account. We are here to help you and will be happy to answer any questions you may have about your treatment or insurance coverage

**Patient Financial Agreement**

I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. I have read the above Patient Financial Policy and have provided the Practice with true and correct insurance information. I will notify you of any changes in my health insurance coverage. A copy of this agreement may be used in place of the original.

\_\_\_\_\_  
Signature of Patient, Policy Holder or Legal Guardian

\_\_\_\_\_  
Date

Printed Name: \_\_\_\_\_

**Acknowledgement of Privacy Notice Receipt**

**Purpose:** This form is used to document (a) an individual's acknowledgement of receipt of our Privacy Practices Notice or (b) when we have not obtained this acknowledgment, a good faith effort has been made to obtain the acknowledgment.

I have been provided a copy of the Notice of Privacy Practices for Bartow HMA Physician Mgmt. LLC with an effective date of April 14, 2003.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Name of Patient or Patient's Representative: \_\_\_\_\_

If applicable relationship to Patient: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

*For office use only*

Signature by Bartow HMA Physician Mgmt. LLC representative:

I attest that the above information is correct.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_ Title: \_\_\_\_\_