

PATIENT INFORMATION

Date: _____ Doctor: _____ Chart #: _____

Patient Name: _____ Date of Birth: _____

Address: _____ Home Phone: _____

City / State / Zip: _____ Cell Phone: _____

Social Security # _____ Sex: Male Female

Employer: _____ Work Phone: _____

Married Single Divorced Widowed

Pharmacy: _____ PCP: _____

Spouse Name: _____ Spouse SSN: _____ Date of Birth: _____

If a minor, responsible party name: _____

Address (if different): _____

Home Phone: _____ Cell Phone: _____

Date of Birth: _____ Relationship to Patient: _____

Person to Contact in case of Emergency: _____

Phone: _____

Insurance Information (please let us copy your card(s))

If no insurance, how will you be paying your bill today?

Cash Check Visa/Mastercard Debit Card

If interested in using Patient Portal, please provide an e-mail address:

HIPAA (HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT OF 1996)

I understand that, under the HIPAA, I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up amount the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your Notice of Privacy Practice containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practice from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practice.

I understand that I may request in writing that you restrict how my private information is used and disclosed to carry out treatment, payment of health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent you have taken action relying on this consent.

My signature below gives authorization to COLUMBIA UROLOGICAL ASSOCIATES, PA to release any medical information necessary during the course of treatment to insurance companies for payment and/or other hospitals or physicians. I further authorize payment of medical benefits to the physician in the event they file for insurance. I understand that I may be billed for these services and am responsible for payments. I also understand the HIPAA consent above.

Signature: _____ Date: _____

As part of a complete urology exam, a urinalysis will be performed on each visit, unless otherwise indicated. The patient will be notified of the results by the physician upon each occasion.