



NAME: _____ SOCIAL SECURITY #: _____ - _____ - _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____

HOME #: (____) _____ WORK# (____) _____ CELL/OTHER# (____) _____

SEX: M F BIRTHDATE: _____ MARITAL STATUS: Single Married Widowed Separated Divorced

PLACE OF EMPLOYMENT: _____ PHONE: _____

BUSINESS ADDRESS: _____

PRIMARY CARE DR: _____ DR REFERRING YOU HERE: _____

PRIMARY INSURANCE

INSURANCE COMPANY: _____

I.D. #: _____ GROUP#: _____ SOCIAL SECURITY #: _____

SUBSCRIBER: _____ BIRTHDATE: _____ RELATIONSHIP: _____

SUBSCRIBER EMPLOYER: _____

ADDITIONAL INSURANCE

IS PATIENT COVERED BY ADDITIONAL INSURANCE? YES NO

INSURANCE COMPANY: _____

I.D. #: _____ GROUP#: _____ SOCIAL SECURITY #: _____

SUBSCRIBER: _____ BIRTHDATE: _____ RELATIONSHIP: _____

SUBSCRIBER EMPLOYER: _____

DOES YOUR INSURANCE COMPANY REQUIRE THE FOLLOWING?

TO USE A SPECIFIC HOSPITAL OR LAB YES NO Name: _____

A REFERRAL YES NO DID YOU CONTACT YOUR PRIMARY PHYSICIAN FOR ONE? YES NO WHEN? _____

Can we call or mail your home with information relative to your clinical care, including lab results, appointments, insurance items, or other necessary information relative to your treatment at P.V.U.? YES NO

Please list **ANYONE** we should speak to on your behalf regarding the above:

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

Same as above Emergency Contact: _____ Relationship: _____ Phone#: _____

I, the undersigned, certify that I (or my dependent) have insurance coverage with the above insurance company(s) and assign directly to Pioneer Valley Urology, P.C., thereafter known as P.V.U., all insurance benefits, if any, otherwise payable to me for services rendered. I understand that although P.V.U. will bill my insurance company directly, I will ultimately be financially responsible for all charges not covered by my insurance. If my insurance requires a referral to be seen at P.V.U. it is my responsibility to provide this office with the referral. If my insurance company denies payment due to no referral, I the patient, agree to pay P.V.U. in full for any charges incurred during my visit(s). I hereby give my consent to P.V.U. to use and disclose protected health information about me to carry out treatment, payment and healthcare options. I further certify that I have been given a copy of the Privacy Policy of P.V.U..

I, the undersigned, give consent for evaluation and treatment, as deemed medically appropriate, at P.V.U.. I acknowledge that no procedure will be performed without my having been provided appropriate information regarding treatment and possible side effects or consequences.

Patient, Parent or Legal Guardian

Relationship

Date