PATIENT DEMOGRAPHICS

Name:_____ Date of Birth:_____ Sex: [ ] M [ ] F

Address: _____
Street City State Zip

Phone: _____ _____ _____
Home Mobile Work

Marital Status: _____ Social Security Number:_____

Primary Physician: _____ Referring Physician: _____

Employer: _____

GUARANTOR (Responsible Party)

[ ] Same as patient

Name:_____ Date of Birth:_____ Social Security: _____

Address: _____
Street City State Zip

Phone: _____ Relationship to Patient: _____

PRIMARY INSURANCE

(If receptionists scanned cards, do not worry about this section)

Insured's Name: _____
DOB & SSN: _____
Ins Co. & Billing Address: _____
_____
_____
Group or Policy #: _____

SECONDARY INSURANCE

Insured's Name: _____
DOB & SSN: _____
Ins Co. & Billing Address: _____
_____
_____
Group or Policy #: _____

AUTHORIZATION TO RELEASE INFORMATION ASSIGNMENT OF INSURANCE BENEFIT

I hereby authorize release of information necessary to file a claim with my insurance company and assign to Chalian & Leak Urology, Ltd all money to which I am entitled for medical or surgical expense relative to the service reported herein, but not to exceed my indebtedness to Chalian & Leak Urology, Ltd. It is understood that any money received, over and above my indebtedness, will be refunded to me when my bill is paid in full.

I understand I am financially responsible for charges not covered by my insurance. In the event unpaid charges are referred to an attorney for collection or a collection agency for collection, I understand I will pay all attorney fees, court costs and/or collection fees of 33 1/3% in the enforcement of the unpaid charges.

A PHOTOSTATIC COPY OF THIS AUTHORIZATION SHALL BE CONSIDERED AS VALID AS THE ORIGINAL.

_____ _____/_____/_____
Signature Date