Patient Demographics

ENTIRE FORM MUST BE COMPLETED—WE WILL BE GLAD TO ASSIST YOU

Patient Name____ Marital Status: ☐S ☐M ☐D ☐W
Last First Middle

Social Security #___________________ Date of Birth: ________________ Age: ____________

Race: ____________________________ Ethnicity: ☐Hispanic/Latino ☐Not Hispanic/Latino ☐Other

Mailing Address: ____
Street City State Zip

Cell Phone: ___________________ Home Phone: _________________ Email: _______________________

Employer: __________________________________ Work Phone:______________________

Spouse Name: ________________________________Spouse Date of Birth:_________________________

RESPONSIBLE PARTY INFORMATION (IF OTHER THAN THE PATIENT-IN CASE OF MINOR OR GUARDIAN)

Responsible Party Name:_________________________________ Social Security #:________________________

Responsible Party Address:____

Cell Phone: _____________________ Home Phone: ___________________ Work Phone___________________

Referring Physician:____

Primary Insurance: ____

Secondary Insurance (If Applicable): ____

Please give the name and number of someone (not listed above) that we may contact if we cannot reach you.
____

I give consent for Urology Associates of Mobile, PA to contact other physicians and/or utilize Pharmacy Benefits Management regarding my medications.
☐ Yes ☐No

I authorize any holder of medical or other information about me to release to my insurance company or the social security administration and health care financing administration any information needed for this or a related medical claim. I request payment of medical insurance benefits either to myself or Urology Associates of Mobile, P.A. on any bills for services furnished to me. I understand that some services are considered "non-covered" and my insurance plan will not pay for them. I will assume the responsibility for payment of any "non-covered" services.
AGREEMENT TO PAY: I, the undersigned, accept the fee charged as legal and lawful debt and agree to pay said fee including the cost of collection, (33.33%), attorney fees, and/or court costs is such be necessary, waiving now and forever the right to claim exemption under the constitution and laws of the state of Alabama, or any other state.
EXPRESS PRIOR CONSENT TO CONTACT CONSUMER BY CELL PHONE: You agree, in order for us to service your account or to collect monies you may owe, we and/or our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address your provide to use. Methods of contact may include using pre-recorded/artificial voice

messages and/or use of automatic dialing device, as applicable. I/we have read this disclosure and agree that Urology Associates of Mobile, its employees, and/or agents may contact me as described above.

____ _____________________________________
SIGNATURE DATE