EAST VALLEY
UROLOGY CENTER

Today's Date: _____ / _____ / _____	Primary Care Physician:

PATIENT INFORMATION

Last Name:	First:	Middle:	Marital status:

Is this your legal name? ○ Yes ○ No	If not, what is your legal name?	Former name:	Birth Date:	Age:	Sex: M / F

Address:

City: State: Zip Code:

Social Security Number:	Home Phone:	Cell Phone:
Occupation:	Employer:	Employer Phone:

How did you hear about us? **EMAIL:**

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Primary Insurance Company:

Subscriber's Name:	SSN:	Birth Date:	Group #:	Policy #:	Co-payment: $

Occupation:	Employer:	Employer Address:	Employer Phone:

Patient's relationship to subscriber:

Name of secondary insurance (if applicable):	Subscriber's Name:	Group #:	Policy #:

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home Phone:	Work Phone:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize East Valley Urology Center or insurance company to release any information required to process my claims.

_____ _____

Patient/Guardian Signature Date

EAST VALLEY
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Practice may disclose your health information without your authorization when permitted or required by law, including:

- For public health activities including reporting of certain communicable diseases.
- For workers' compensation or similar programs as required by law.
- To authorities when we suspect abuse, neglect, or domestic violence.
- To health oversight agencies.
- For certain judicial and administrative proceedings pursuant to an administrative order.
- For law enforcement purposes.
- To a medical examiner, coroner, or funeral director.
- For the facilitation of organ, eye, or tissue donation if you are an organ donor.
- For research purposes under strictly limited circumstances.
- To avert a serious threat to your health and safety or that of others.
- For governmental purposes such as military service or for national security.
- In the event of an emergency or for disaster relief. □ In any instance required by law.

This practice may also disclose your information to family members and/or other persons involved in your care or payment for your care. It may leave message for you at home or work about your visits or test results. If you do not want us to do so, please inform our Privacy Officer/Office Manager in writing.

Communication Consent

Can we leave detailed or confidential message on your home number? Yes _____ No _____

Can we leave detailed or confidential message on your cell number? Yes _____ No _____

Can we speak to anyone other than you regarding lab results, radiology results or other issues regarding your health? Yes _____ No _____

List of individuals we may speak with:

Name: _____ Relationship: _____

MUST SIGN BELOW FOR ALL INFORMATION GIVEN:

My signature below acknowledges that I have received a copy of the East Valley Urology Center Notice of Privacy Practices and have read the Communication Consent.

_____

Patient/Guardian Name (Printed) Date

_____

Patient/Guardian Name (Signature)

EAST VALLEY
UROLOGY CENTER

"We are committed to providing the best possible medical care and patient experience to our patients. Patients knowing and understanding their financial responsibility is a key component to a positive care experience and a successful physician to patient relationship."

Please read thoroughly and carefully.

Non-Covered Services: Patients are responsible for knowing their insurance coverage and bringing their insurance cards to their appointments. Please know your insurance benefits before each visit. You will be asked to pay for any services that are not covered by your insurance plan.

Correct Insurance Information: You are responsible for providing us with the most correct and update information about your health insurance. It is your responsibility to notify us immediately of a change to your health insurance plan or change in insurance status. If we have incorrect insurance information, outstanding balances will be billed to you directly.

Payment is required at the Time of Service: You are responsible for paying deductibles, copayments, coinsurance and other out of pocket expenses at time of service. If we are unable to verify your insurance coverage, you will be asked for payment. In addition to cash payments and checks, we also accept most major credit cards. Patients who are not covered by health insurance are required to pay for the provided services at the time of service.

Missed Appointments: We require a 24hr notice if you cancel an appointment or surgery. If you no-show or cancel an appointment within 24hrs of the scheduled time, there is a $50.00 charge (same-day appointment cancelations very). If you no-show or cancel a surgery within 24hrs of the scheduled time, there is a $100.00 charge (same-day surgery cancelations very). If there are multiple occurrences of this behavior, the patient may be subject to discharge from the practice.

Special Insurance Processing Requests: The Arizona State Constitution permits insured individuals to pay directly for health care services, if they so desire. If you choose to pay for health care services, your health care provider will not submit a claim to your health plan. It is your responsibility for notifying your provider's office when you do not wish a claim to be submitted on your behalf.

Related Facilities or Services: EVUC Physicians may have a financial interest in where you are referred for treatment. This may include, but not limited to surgery centers, lithotripsy centers, pathology labs, oncology treatment centers, radiation facilities that perform CT and MRI scans and other medical and non-medical related entities.

Collection Agency Fees: When patient accounts become extremely delinquent, patients or patient guarantors agree to pay collection agency or attorney fees or not less than thirty five (35) percent. The collection agency fees will be added to the patient's outstanding balance and collected by the collection agency upon referral to the agency.

Administrative Charges: Patients may incur, and are responsible for, the payment of additional charges at the discretion of EVUC. The charges may include but are not limited to (subject to change at any time). • Charge for Returned Checks $25.00 • Charge for copying and distribution of patient medical records. $50.00 (payment required prior to distribution) • Charge for forms completion, including but not limited to disability and FMLA forms. $50.00 (payment due prior to completion).

Patient Authorizations: By my signature below, I hereby authorize EVUC and the physicians, staff, labs, and hospitals associated with EVUC to release ALL medical and other information acquired in the course of my examination and/ or treatment to the necessary insurance companies, third party payers, and/or other physicians or healthcare entities required to participate in my care.

Printed Name of Patient	Printed Name of Guardian (if Applicable)
Signature of Patient or Guardian	Date

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