

Date: _____

Southeast Texas Urology Associates, L.L.P.

Referring/Primary Physician: _____

Name: _____ Social Security #: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Gender: M / F Marital Status (circle one) S M D W

Home #: _____ Work #: _____ Cell #: _____

Email: _____

Emergency Contact (other than Nearest Relative): Name: _____ Relationship: _____

Address: _____ Phone #: _____

City: _____ State: _____ Zip: _____

Nearest Relative: Name: _____ Relationship: _____

Address: _____ Phone #: _____

City: _____ State: _____ Zip: _____

Patient Employer: _____

Address: _____ State: _____ Zip: _____

Phone #: _____ Employment Status: _____

Responsible Party Information (if different from patient):

Name: _____ Relationship: _____

Date of Birth: _____ Phone #: _____

Address: _____

City: _____ State: _____ Zip: _____

Insurance Information:

Primary Insurance Company: _____

Secondary Insurance Company: _____

It will be my responsibility to call for results and all lab and x-rays through this office if not informed in a timely manner.

Signature _____

I authorize all medical and/or surgical treatment to be rendered by Dr. J. Denton Harris, Dr. John Henderson, Dr. Steven A. Socher, Benjamin Strahan, FNP-C and Anthony Scoggins, ACNP-BC and I assume financial responsibility. I assign all benefits to be paid to Southeast Texas Urology Associates - Dr. J. Denton Harris, Dr. John Henderson, Dr. Steven A. Socher, Benjamin Strahan, FNP-C and Anthony Scoggins, ACNP-BC under my medical Insurance Program and give my authorization to release records if necessary including DX and treatment to Insurance Company, physicians. etc.

Signature _____

Southeast Texas Urology Associates, L.L.P.

Name: _____ Age: _____ Date of Birth: _____
 Allergies: _____

***Do you drink alcohol?**
 Yes / No
 Social Light Moderate

Do you smoke/dip?
 Yes / No
 How much? _____
 How long? _____

Did you ever smoke?
 Yes / No
 When did you quit? _____

Height _____
 Weight _____

Pneumonia Immunization
 Yes / No When: _____

Last Colonoscopy:

Preferred Pharmacy: _____ **Mail order:** _____

<i>Check any illness the patient or blood relative had.</i>	Patient	Mother	Father	Sister	Brother
Reaction to Anesthesia					
Emphysema/ Asthma					
Kidney Stones					
Hepatitis					
Bronchitis					
Heart Attack					
High Blood Pressure					
Congestive Heart Failure					
Heart Disease					
Stomach ulcers/ GERO					
Diabetes					
Bleeding Problems					
Kidney Problems					
Thyroid Disease					
Stroke					
Cancer Type: _____					
Kidney Cancer					
Bladder Cancer					
Prostate Cancer					
High Cholesterol					
Gout					

Surgeries:	Date
_____	_____
_____	_____
_____	_____
_____	_____

Medications:

Do you have access to your Patient Portal?
 Yes / No
 Email: _____

Statement of Patient Financial Responsibility
Southeast Texas Urology Associates, L.L.P.

The doctors of Southeast Texas Urology appreciate the confidence you have shown in choosing them to provide your urological care. We are committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

Patient Financial Responsibilities

1. The patient (or patient's guardian, if a minor) is ultimately responsible for the payment for their treatment and care. You are responsible for knowing your own plan benefits and coverage.
2. We are pleased to assist you by billing to our contracted insurers. However, the patient is required to provide us with the most correct and updated information about their insurance, and will be responsible for any charges incurred if the information provided is not correct or updated.
3. Patients are responsible for the payment of co-pays, coinsurance, deductible, and all other procedures or treatment not covered by their insurance plan. Payment is due prior to any surgery or at the time of service for office encounters. Amounts collected are estimates only. Insurance companies do not guarantee benefits. After the claim is filed you may be due a refund or owe additional funds. For your convenience, we accept cash, check, and most major credit cards.
4. If you do not know your co-pay we will collect a minimum fee of \$30.00. Our billing department will bill or credit your account accordingly after your insurance pays their portion. If you are not prepared or unable to pay your co-payment at the time of your visit, we will kindly reschedule your appointment for a more convenient time.
5. Overpayment will be refunded after all charges have been processed and paid by your insurance company. A refund check will be written and mailed within 15 days of your verbal or written request.
6. Patients may incur, and are responsible for the payment of additional charges at the discretion of Southeast Texas Urology. These charges may include (but are not limited to):
 - Charge for returned checks.
 - Charge for copying and distribution of patient medical records.
 - Charge for extensive forms completion.
 - Any costs associated with collection of patient balances.
7. If you have managed care insurance, it is your responsibility to obtain a referral. As there are hundreds of insurance plans and we do not participate with all, you need to make sure Southeast Texas Urology is part of your network.
8. Patient accounts 90 days past due will be referred to an outside billing service.

I have read, understand, and agree to the provisions of the Patient Financial Responsibility Form.

Signature of Patient or Guardian

Date

Print Signature

Date of Birth

Professional services for lab and radiology readings will be billed separately by a third party.

Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Signature of Patient or Personal Representative

Date

Name of Patient or Personal Representative

Description of Personal Representative's Authority

The physician may discuss my medical history with the following people:

_____	_____ Relationship to Patient
_____	_____ Relationship to Patient
_____	_____ Relationship to Patient
_____	_____ Relationship to Patient