Thank you for entrusting Kansas City Urology Care, PA with your urologic care. Our physicians and office staff are eager to serve you.

In order to provide you with the best services possible, we ask that you please complete the enclosed paperwork and bring it with you to your appointment.

- **Please arrive 15 minutes early for your appointment. If your paperwork has not been completed, please arrive 30 minutes before your appointment or we reserve the right to reschedule your visit.**
- **If you have had any x-rays, CT scans, MRI's, bone scan or any records that pertain to your urology needs, please bring your films with you at the time of your appointment.**
- Please bring your insurance cards and medication list with you.
- Please be prepared to pay your co-pay at the time of your visit
- If your insurance requires a written referral to see a urologist (specialist), please bring a referral form completed by your primary care physician at the time of your visit. If you arrive without a valid referral form we reserve the right to reschedule your appointment because of your insurance requirements.
- **Self-pay patients please come prepared to make payment in full at the time of your visit. If you pay in full at the time of service your charge will be discounted 30%. If you cannot pay in full please be prepared to render a minimum of $100.00, we will bill you for the additional charges.**
- **Please be advised that a NO SHOW fee of $50 will apply if you fail to cancel or reschedule your appointment 24 hours prior.**

Thank you for your assistance in helping us expedite your appointment!

Patient Financial Policy

Thank you for choosing Kansas City Urology Care, PA as your urology health care provider. We are committed to providing you with the highest quality medical care, in a supportive, empathetic and respectful manner. If you have special needs, we are here to work with you.

The following information is provided to avoid any misunderstanding or disagreement concerning payment for professional services. Your clear understanding of our "Patient Financial Policy" is important to our professional relationship. Please ask if you have any questions about our fees, our policies or your responsibilities. Carefully review the following information and return this form to us with your signature and today's date.

Insurance

It is the patient's responsibility to provide the clinic with current insurance information since our practice participates with a variety of insurance plans. **Your insurance policy is a contract between you and your insurance company.** We consider an insurance card similar to a credit card because you are asking us to bill another party (your insurance) for charges for the services you have been provided.

As a courtesy, we will file your claims for you. However, we will not become involved in disputes between you and your insurance carrier. This includes, but is not limited to, deductibles, co-payments, non-covered charges and "usual and customary" charges. We will supply information as necessary. **You are ultimately responsible for the timely payment of your account.**

If we DO participate with your insurance company, all services performed in our office will be submitted to them, unless we have received prior notification of non-covered services. All copays and deductibles are the patient's responsibility. Copay's are due at the time of service.

If we DO NOT participate with your insurance company, we will file the insurance claim and accept the payment, but we will not accept the contractual adjustment. That balance will be the patient's responsibility and any balances that are not covered will be the patient's responsibility.

Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. It is your responsibility to know if a certain procedure is not covered, please check your insurance handbook.

It is your responsibility to bring any required referrals for treatment at, or prior to the visit. If you do not have the referral, your visit may be rescheduled, or you may be financially responsible.

Co-pays

Your insurance company requires us to collect co-payments at the time of service. Waiver of co-payments may constitute fraud under state and federal law. Please help us in upholding the law by paying your co-payment at each visit. For your convenience we accept cash, check, or credit card (MasterCard, VISA, AMEX or DISC). If you do not bring proper payment to your visit, you may be asked to reschedule your appointment except in the case of a medical emergency.

Patients with NO Medical Insurance

If you do not have group or individual medical insurance, payment for professional services is expected at the time of service. As a courtesy, the practice offers a 30% discount of billed charges, to anyone with no insurance if paid at the time of service. This discount is available **ONLY ON** the actual date of service.

If unable to pay at the time of service, at the discounted rate (30% of billed charges), we require a $100 down-payment toward all billed services, which will be at the full fee amount. If you have questions, we would recommend that you contact our billing department (913-341-7985) prior to your appointment.

Waiver of Patient Responsibility

It is the policy of the practice to treat all patients in an equitable fashion related to account balances. The practice will not waive, fail to make reasonable collection efforts, or discount co-payments, co-insurance, deductibles, or other patient financial responsibility in accordance with state and federal law, as well as participating agreements with payers. Full or partial financial responsibility may only be waived in accordance with the Kansas City Urology Care's Charity Care Policy.

Un-Paid Balances & Payment Arrangements

If your insurance company has not paid the balance in full or you are unable to pay the balance in full, you will receive a statement notifying you of the amount due, you may call our billing office at (913)-341-7985 to set up payment arrangements if necessary. If you fail to make payment in full, within 120 days, for the services that are rendered to you, your outstanding balance may be considered for further collection activity.

Late Arrivals

A late arrival, not considered to be the responsibility of Kansas City Urology Care, will be registered and worked into the schedule as soon as possible. If the patient is more than 30 minutes late, the appointment may be rescheduled.

No-Shows

Kansas City Urology Care, PA may charge a $50 "no-show" fee in the event that you do not show for your appointment and in which you do not cancel or reschedule with 24 hours' notice. This will be applied to your account.

Returned Checks

The charge for a returned check is $30 payable by cash or money order. This will be applied to your account in addition to the insufficient funds amount. You may be placed on a "Cash Only" basis following any returned check.

Minors

Our practice does not treat minors without the presence of a parent(s) or guardian(s). If the patient is a minor (under 18 years of age), the parent(s) or guardian(s) is responsible for full payment and will receive the billing statements.

Divorce Decrees

Kansas City Urology Care is not party to any divorce decrees, so any outstanding balance is still the responsibility of the patient or the legal guarantor of the patient, in the case of a minor.

Special Form Fees

If you require any special forms to be completed (for example; FMLA, Work Comp or Disability) by a physician, the patient/guarantor will be responsible for any fees related to the service.

Medical Record Copies

Your medical record is the property of Kansas City Urology Care, PA. If you would like to request a copy of your medical records, for yourself or to be mailed to another provider, please contact your physician's office to obtain the proper Medical Records Request form.

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Kansas City Urology Care may charge a reasonable cost-based fee pursuant to 45 CFR 164.524. Kansas City Urology Care has developed a fee structure that is slightly below the Missouri and Kansas Department of Health Services maximum standards:

- Clerical fees $18.50
- For the first 250 pages $ 0.50 per page (maximum $125.00)
- For each page after 250 $ 0.45 per page
- Plus actual postage

Kansas City Urology Care must emphasize that as healthcare providers, our relationship is with you, not your insurance company. While filing the insurance claims is a courtesy we extend to our patients, all charges are strictly your responsibility from the time services are rendered. Therefore, it is often necessary for you to inquire and explore your benefits with your insurance carrier. We do realize that temporary financial problems may affect timely payment, but if such problems do arise, we encourage you to contact us promptly for assistance in the management of your account at 913-341-7985.

Kansas City Urology Care believes that a good patient-to-physician relationship is based upon understanding and good communication. Thank you for understanding our "Patient Financial Policy". We appreciate the opportunity to provide you with your urological care. Your assistance and cooperation will be most appreciated.

If you're a new patient please circle one of the following to help us know how you heard about KC Urology:

PCP Radio Internet TV Other___________

PATIENT INFORMATION

Patient Name: ____ Date: ___________________

Address: _________________________________ City/State:_____________________________ Zip: ________

Date of Birth: ______________ Age: _____ Male or Female (circle one)

Last 4 digits Social Security #: _______________ Marital Status S__ M__ D__ W__ No. of Children: _______

Home Phone: _________________ Cell Phone: _________________ e-mail: _____________________________

Referring Physician:_____ ____ Phone: __________________________

Primary Care Physician: _____________________________________ Phone: __________________________

Primary Insurance:________________________________ID#_______________________ Group #__________

Insured's Name:____ Date of Birth: _________________

Relationship to Patient: _______________________________Contact Phone #:__________________________

Secondary Insurance: ____________________________ ID# ________________________Group #__________

Insured's Name:____ Date of Birth: _________________

Relationship to Patient: _______________________________Contact Phone #:__________________________

Primary Pharmacy: __________________________________ Address: _____________________________

City/State/Zip: ______________________________________ Phone #: _____________________________

Mail Order Pharmacy: _______________________________ Address: _____________________________

City/State/Zip: ______________________________________ Phone #: _____________________________

Emergency PATIENT SPOUSAL / PARENT CONTACT INFORMATION

Name: ____Relationship to Patient __________________

Home Phone: ____ Cell Phone: ___________________________

____
(Patient Name)

INSURANCE CONSENT

I hereby authorize release of information to my insurance companies and payments to be made directly to my physicians. This form may be used for all of my insurance companies, and I authorize this practice to act as my agent to help me secure payment from my insurance companies. I understand that I am responsible for my bill and am subject to attorney fees, collection fees/charges, and any other charges incurred if my portion of the balance is not paid when due.

____
Initials

MEDICAL RECORDS RELEASE AUTHORIZATION

I authorize the Kansas City Urology Care, PA to release to the appropriate person, corporation, or other entity any diagnostic and therapeutic information (including any treatment for alcohol or drug abuse and any psychiatric or psychological treatment) as may be necessary to determine health care benefits entitlement for me under any insurance policy or other type of health care benefits plans or as may be appropriate for the purpose of analysis or research regarding reimbursement of doctors and other health care providers. I authorize Kansas City Urology Care, PA to process payment claims for health care services provided to me. I agree to cooperate and execute such other authorizations and releases for the above purposes as deemed necessary by Kansas City Urology Care, PA upon the practice's request. Kansas City Urology Care, PA may utilize information in my medical record that is necessary for research for quality improvement purposes.

____
Initials

NOTICE OF PRIVACY PRACTICES

As required by the Privacy Regulations set forth in the Health Insurance Portability & Accountability Act of 1996 (HIPAA), Kansas City Urology Care, PA has issued a Notice of Privacy Practice (Notice) to the me. I acknowledge I been given a copy of the Notice, which describes how a patient's health information is used and shared. I understand that Kansas City Urology Care, PA has the right to change this Notice at any time, and if the Notice changes, a current copy may be obtained by contacting Kansas City Urology Care, PA or by visiting the Kansas City Urology Care, PA website.

____
Initials

FINANCIAL POLICY & PAYMENT GUARANTEE

I have received and read and fully understand the financial policy set forth by Kansas City Urology Care, PA and I agree to the terms of this financial policy. I agree that the terms of the financial policy may be amended by the practice at any time without prior notification to me, the patient.

____
Initials

I understand that, in consideration of the services rendered to me, I am subject to all attorney fees, collection charges, and any other changes incurred if my portion of the bill is not paid when due.

____
Initials

DME WARRANTY COVERAGE

I understand Kansas City Urology Care, PA honors all warranties of manufacturers of the equipment the practice provides.

____
Initials

MEDICARE BENEFITS CONSENT

If I am covered by Medicare, I certify that the information given in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my, as the patient's, behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit claim to Medicare for payment to the patient.

____
Initials

Patient Signature:______________________________________ Date:______________________________

Witness Signature:______________________________________ Date: ______________________________

Authorization to Disclose Protected Health Information (PHI)
Please Print

Today's Date: ______________________

Patient Name: ____________________________________ Date of Birth: ______________________________________

Address: ____

Preferred Phone Number for Contact: ____

Describe the information you approve disclosure of:

- ☐ All aspects of my healthcare as allowed to me under applicable law
- ☐ Other: ____

To whom you approve disclosure (spouse, family, friend, etc.)

Name: ____ Relationship: ___________________________________

Phone #: _________________________________ Address: ____

City: ____________________________________ State: _______________ Zip Code: ____________________________

Okay to leave a message: ______________________

Name: ____ Relationship: ___________________________________

Phone #: _________________________________ Address: ____

City: ____________________________________ State: _______________ Zip Code: ____________________________

Okay to leave a message: ______________________

Name: ____ Relationship: ___________________________________

Phone #: _________________________________ Address: ____

City: ____________________________________ State: _______________ Zip Code: ____________________________

Okay to leave a message: ______________________

- I understand by completing this consent, you are authorizing KCUC physicians and staff to leave a message on an answering machine, voicemail or with a specified individual, which may include sensitive and/or PHI. You may specify what information is left and with whom by noting the information above.
- I understand that I still have a right to access my PHI as allowed under applicable law.
- I understand that I may revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written authorization to KCUC. I understand that my revocation will not apply to information already released in response to this authorization.

Signature of Patient or Legal Representative: ____

Printed Name of Legal Representative: ________________________________Relationship to Patient _______________

Address and Phone Number of Legal Representative:

____

MEDICARE SECONDARY PAYER QUESTIONNAIRE
(TO BE COMPLETED FOR **ALL** MEDICARE PATIENTS)

PATIENT NAME: ______________________________PATIENT MEDICARE # _______________

If any answers to questions 1 through 4 are yes, the corresponding section of the "Other Insurance" form must be filled out completely.

	YES	NO
1. Is the patient a Veteran?	_____	_____
Did the VA refer you here for treatment?	_____	_____
Does the patient have a VA "fee basis ID Card?"	_____	_____
2. Do you have a Federal Black Lung card?	_____	_____
3. Is this medical condition due to an accident of any kind?	_____	_____

If yes was it: Work Related ☐ Auto ☐ Injured in own home ☐ Other ☐

4. Is the patient covered by an employer's health insurance plan through their own employment or that of a family member? (Not retiree coverage)	_____	_____

(**OFFICE USE ONLY** - This section must be updated or documented for each patient visit.)

Date of Service	Initial	Date of Service	Initial	Date of Service	Initial
___________	________	___________	________	___________	________
___________	________	___________	________	___________	________

MEDIGAP AUTHORIZATION FORM

I hereby authorize payment of my Medigap benefits to Kansas City Urology Care, PA for all claims filed on my behalf. This authorization applies to all services until my representative or I revoke it.

BENFICIARY SIGNATURE: ____

MEDIGAP INSURER: ____

MEDIGAP ADDRESS: ____

____

MEDIGAP TELEPHONE #: ____

MEDIGAP POLICY #: ____

(**OFFICE USE ONLY** - This section must be updated or documented for each patient visit.)

Date of Service	Initial	Date of Service	Initial	Date of Service	Initial
___________	________	___________	________	___________	________
___________	________	___________	________	___________	________
___________	________	___________	________	___________	________

Patient Name ______________________________

OTHER INSURANCE INFORMATION

(TO BE COMPLETED IF ANY OF THE FIRST FOUR QUESTIONS ON THE M.S.P. QUESTIONNAIRE ARE ANSWERED "YES")

VETERANS ADMINISTRATION AUTHORIZATION INFORMATION	**Yes**	**No**
Does the patient authorize Kansas City Urology Care, PA to bill the VA?	___	___

BLACK LUNG INSURANCE INFORMATION	**Yes**	**No**
Are the services you are receiving today related to lung disease	___	___

If the answer is "YES", submit claims to:

Federal Black Lung Program
PO Box 828
Lanham-Seabrook, MD 20703-0828

(**OFFICE USE ONLY** - This section must be updated or documented for each patient visit.)

Date of Service	**Initial**	**Date of Service**	**Initial**	**Date of Service**	**Initial**
____________	________	____________	________	____________	________
____________	________	____________	________	____________	________
____________	________	____________	________	____________	________
____________	________	____________	________	____________	________

KCUC
KANSAS CITY UROLOGY CARE, P.A.

Patient History Form for Use with EMR

This is a confidential record and will be kept in your electronic patient chart

Information contained here will not be released to anyone without your authorization to do so.

TODAY'S DATE _______ / _______ / _______ **DATE OF BIRTH _______ / ________ / _______**

LAST NAME _________________________________ FIRST NAME ______________________________ M.I. ___

Reason for seeing the physician on the first visit: ____

Have you been exposed to or currently have TB (tuberculosis)? ***Y*** ***N***

Have you received the Pneumonia Vaccine in the last 9 years? ***Y*** ***N*** ***Date________________***

ALLERGIES/REACTIONS TO ANY MEDICATION OR FOOD:

____

____

LIST CURRENT MEDICATIONS *(include over the counter items such as aspirin)*

MEDICATION/DOSAGE	MEDICATION/DOSAGE
1. ____________________________	7. ____________________________
2. ____________________________	8. ____________________________
3. ____________________________	9. ____________________________
4. ____________________________	10. ____________________________
5. ____________________________	11. ____________________________
6. ____________________________	12. ____________________________

OVER-THE-COUNTER SUPPLEMENT MEDICATIONS *(if nothing marked then NONE APPLY)*

Echinacea	Metabolife	Garlic	Ginkgo	Ginseng
Kava	St. Johns Wort	Valerian	Fish Oil	Vitamin E

Other_______________________________________ Other____

Are you required to take antibiotics with dental work? N Y

LAST NAME ______________________________ FIRST NAME ______________________________ DOB ________________

PAST SURGICAL HISTORY – Check previous surgeries & provide date *(if nothing marked then NONE APPLY)*

__Bladder augmentation__________________________
__Bladder suspension____________________________
__Cystectomy____________________________________
__Cystoscopy____________________________________
__Green light PVP_______________________________
__Hydrocele repair______________________________
__Kidney Stone Removal__________________________
__Laparoscopy___________________________________
List type of Laparoscopy
__Lithotripsy___________________________________
__Nephrectomy___________________________________
__Pacemaker_____________________________________
__Percutaneous nephrolithotomy__________________
__Pubovaginal sling_____________________________
__Tubal ligation________________________________
__Ureteroscopy-stent____________________________
__Vasectomy_____________________________________
__Other____

__Adrenalectomy_________________________________
__Appendectomy__________________________________
__Back surgery__________________________________
__Breast biopsy_________________________________
__CABG____
__Cesarean section______________________________
__Cholecystectomy_______________________________
__Colon surgery_________________________________
__ Colonoscopy _________________________________
__Coronary Stent________________________________
__Gastric bypass________________________________
__Heart Valve Replacement_______________________
__Hernia repair_________________________________
__Hip replacement_______________________________
__Hysterectomy__________________________________
__Knee replacement______________________________
__Mastectomy____________________________________
__Other____

PAST MEDICAL HISTORY – Check any previous past medical problems *(if nothing marked then NONE APPLY)*

___ Anemia
___ Angina (Chest Pain)
___ Arthritis
___ Asthma
___ BPH
___ Cancer__________________
List type of cancer
___ CVA (Stroke)
___ Chronic UTIs
___ Congestive heart failure
___ COPD
___ Coronary artery disease
___ Depression

___ Diabetes 1 OR 2 (circle one)
___ Diverticular disease
___ GERD (Gastric Reflux)
___ Gout
___ Hepatitis C
___ High Cholesterol
___ Hyperlipidemia
___ High Blood Pressure
___ Hypothyroid
___ Inflammatory bowel disease
___ Liver disease
___ Lupus

___ Migraine headaches
___ Multiple Sclerosis
___MI (Heart Attack)
___ Osteoarthritis
___ Osteoporosis
___Peptic Ulcer Disease
___Peripheral Vascular Disease
___ Renal Disease
___ Dialysis
(___Hemo ___Peritoneal)
___ Rheumatoid Arthritis
___ Seizure Disorder
___ Urolithiasis (Kidney Stones)

Other________________________ Other________________________

LAST NAME _______________________________ FIRST NAME _______________________________ DOB _________________

FAMILY HISTORY ***Indicate*** *what family member has the condition (**FATH, MOTH, SIS, BRO, DAU, SON)***

Anesthesia Problems _____	Heart Disease ____________	Lung Problems _____________	Prostate Cancer ___________
Bladder Cancer ___________	High Blood Pressure ______	Metastatic Prostate Ca ______	Strokes _________________
Bleeding Disorders _______	Kidney Cancer ___________	Ovarian Cancer _____________	Testicular Cancer __________
Breast Cancer ____________	Kidney Disease ___________	Pancreatic Cancer ___________	Unknown History ________
Colon Cancer ____________	Kidney Stones ____________	Polycystic Kidneys ________	Diabetes ___________

Other Cancer (specify)

____

SOCIAL HISTORY: Please Circle Answers

Marital Status: Married Single Divorced Widowed Legally Separated Annulled Life Partner Unknown

Smoking Status: (please circle and answer as appropriate)

Current Every Day Smoker? When did you start smoking? _______________ Packs smoked per day? _______________

Current Some Day smoker? When did you start smoking? _______________ Packs smoked per day? _______________

Former Smoker? When did you quit? __________ Packs smoked per day? ____ How long did you smoke? _____

Never Smoked Smoker, Current Status Unknown Unknown if ever smoked

Do you use Smokeless Tobacco? (please circle) Yes No

How many caffeinated drinks do you have each day? (please circle) 0 1 2 3 4+

Do you drink alcohol? (please circle) Yes_________ Not Anymore Never Drank

Type of alcohol consumed? **(please circle)** Beer Liquor Wine

Drinking habits? (please circle) Social Light Moderate Excessive

Do you use recreational drugs? (please circle) Yes No

Have you had a blood transfusion (please circle) Yes No

Race: (please circle) Unknown American Indian/Alaska Native Black/African American Eskimo

Native Hawaiian/other Pacific Islander White Asian Declined to Specify Hispanic/Latino

Language: (please circle) English Arabic Chinese Declined French German Italian Japanese

Portuguese Russian Spanish Vietnamese Other ______________________

Ethnicity: (please circle) Hispanic/Latino Not Hispanic/Latino Declined Unknown

Current/Former Occupation? ____

LAST NAME ______________________________ FIRST NAME _______________________ DOB _________

REVIEW OF SYSTEMS – **Please circle any symptoms you are currently experiencing.**

Constitutional:	Fever	Chills	Weight Loss	
Eyes:	Blurry Vision	Cataracts	Glaucoma	
Ears, Nose, Mouth, Throat:	Hearing Loss	Nasal Stuffiness	Sore Throat	
Cardiovascular:	Chest Pains	Swollen Ankles	Irregular Heartbeat	
Respiratory:	Shortness Of Breath	Wheezing	Chronic Cough	Known TB Exposure
Gastrointestinal:	Abdominal Pain	Nausea/Vomiting	Change In Bowels	
Musculoskeletal:	Chronic Back Pain	Chronic Neck Pain	Sore Muscles	
Integumentary/Skin:	Rash	Persistent Itching	Skin Cancer History	
Neurological:	Numbness	Tingling	Dizziness	
Hematologic/Lymphatic:	Swollen Glands	Abnormal Bleeding	Transfusion History	
Psychiatric:	Anxiety	Depression		

Recent Colonoscopy:	**Date Of Procedure:**
Recent Pneumonia Vaccine:	**Date Of Injection:**

APPROXIMATE HEIGHT: ______________________________ **WEIGHT:** _________________________

Physician Signature: ____ Date: ___________________________

Patient Name: ____

WORKER'S COMPENSATION INSURANCE INFORMATION

Date of Accident ______________________________

Employer Name ______________________________

Employer Address ______________________________

____

Employer Phone # ______________________________

Employer Identification # ______________________________

Name of Insurance Company ______________________________

Name of Person/Company Insured ______________________________

Insurance Company Claim/Policy # ______________________________

Worker's Compensation Claim # ______________________________

Name of Worker's Compensation Agency ______________________________

Address of Worker's Compensation Agency ______________________________

____

Phone # of Worker's Compensation Agency ______________________________

Has the case been settled? Yes ____ Date ______________ No _____

Name of Patient's Legal Representative (if any) ______________________________

Phone # of Legal Representative ______________________________

GROUP HEALTH PLAN INFORMATION

Kansas City Urology Care, PA will take a copy of the patient's insurance card.

Insured's Name ______________________________

Relationship to Patient ______________________________

Employed Full Time ☐ Employed Part Time ☐

Employer Name ______________________________

Employer Address ______________________________

____

Does employer have greater than 20 employees? Yes ☐ No ☐

More than 100 employees? Yes ☐ No ☐

Patient Name: ____

AUTOMOBILE, NO - FAULT OR LIABILITY INSURANCE INFORMATION

Date of Accident ____

☐ If other than auto, check the box and describe the accident:

____

____

____

Name of Business / Property Owner ____

Address of Business / Property Owner____

Phone # of Business / Property Owner____

Type of Insurance Premises Medical ☐ Liability ☐

Are you or a family member going to file a liability claim in connection with this injury? _______
(Y / N)

* * * * * * * * *

Complete section below if an Auto, Premises Medical, or Liability Claim will be filed.

Name of Policyholder ____

Address of Policyholder____

____

Phone # of Policyholder____

Policy # or Claim Identification#____

Name of Insurance Company____

Address of Insurance Company____

____

Phone # of Insurance Company____

Name of Patient's Legal Representative for this Case (if any)____________________________

Phone # of Legal Representative____