KCUC
Urology & Oncology

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: _____