

Perlow Urology Practice, P.C.

Date: _____ Referred By: _____

Name: _____ Age: _____ D.O.B.: ____/____/____
First Middle Last

SS#: _____ Address: _____ City: _____

State: _____ Zip: _____ Home#: _____ Work#: _____

Cell# _____

Employer: _____ Address: _____ City: _____

State: _____ Zip: _____

Martial Status: _____ Spouse's Name _____ D.O.B.: ____/____/____

Spouse Employer: _____ Address: _____

Person to Notify If Necessary: _____ Relationship: _____

Phone #: _____

How do you wish to pay for your visit today? Cash _____ Check _____ Credit Card _____

INSURANCE INFORMATION:

Primary Insurance Co: _____ Insured: _____

ID #: _____ Phone #: _____

Secondary Insurance Co: _____ Insured: _____

ID #: _____ Phone #: _____

I, the undersigned, acknowledge that it is the policy of this office that payment in full be made at each visit (or with previous arrangements, co-insurance may be accepted), and that I am responsible for the payment off all services rendered for the above patient. I authorize payment of medical benefits to Steven L. Perlow, M.D. when any insurance claim is filed to my insurance carrier on my behalf. I further authorize release of any medical information necessary to process this claim to Steven L. Perlow, M.D., and also certify that the above information is true & correct. I also acknowledge responsibility for obtaining proper referrals and referral #'s as needed from my primary care physician, and for providing this office with current participating hospital & other ancillary providers at which I may be treated while a patient of this practice. Additionally, I understand that I am responsible for bills sent to me for any lab work, pathology specimen evaluation or diagnostic ultrasounds that are not covered by my insurance company, and I understand that these bills may come from a diagnostic company independent of Perlow Urology Practice, P.C. I have also read and understand the HIPAA regulations privacy act.

Signature: _____

Date: ____/____/____