Urology Associates, LLC Patient Information

Have you previously received care by any of the following physicians? (please circle):
Bruno Williams Ulrich Kim Hall Okotie

Patient's Full Name: _____ SS#: _____
Street Address: _____ City: _____ St: ___ Zip _____
Mailing Address: _____
Home Phone: _____ Cell Phone: _____ Birthdate: _____
Age: _____ Sex: _____ Height: _____ Weight: _____
Employer: _____ Occupation: _____ Work #: _____
EMAIL ADDRESS: _____
Marital Status (Circle One): Single Widowed Divorced Married
Spouse's Name: _____ Employer: _____
Spouse's Work #: _____ Spouse's SS#: _____

Patient/Responsible Party: _____ SS# _____
Address: _____ City: _____ St: _____ Zip: _____
Home Phone: _____ Cell Phone: _____ Birthdate: _____
Employer: _____ Occupation: _____ Work #: _____

Person to contact regarding Medical Care/Appointments, **if applicable**:
Name: _____ Phone#: _____ Relation: _____
Family Physician: _____ Referring Physician: _____
Preferred Pharmacy:_____
Nearest **Local** friend/relative **NOT LIVING WITH YOU**: _____
Phone: _____
May test results be left on answering machine? Yes _____ No _____

Primary Insurance: _____Secondary Insurance: _____
ID Number: _____ID Number: _____
Member: _____Member: _____
Member DOB: _____Member DOB: _____
Employer: _____Employer: _____

Release and Authorization:
I authorize the doctors of Urology Associates, LLC and their staff to give reasonable and proper care. I authorize the doctors to give medical information to other health care provides. I authorize Urology Associates, LLC to release any medical information to my insurance company or HICFA to file a claim for Medical and/or surgical services rendered. I also request that payment under the medical insurance program be made directly to the above named medical group on any bills furnished to me. I understand that I am financially responsible for any balance that is not covered by my insurance provider including Medicare (copy of signature is valid as the original). I am responsible for financial obligations of health services for the above patient and for reimbursement and payment of claims from my insurance company. If for any reason the account should become delinquent, I agree to pay for all collections and legal fees, collection fees which are 30% above the balance. I understand that part of my Urologic care may involve surgery at Mid America Surgery Center. I understand that my Urologist has a percentage of ownership in that facility. I understand that I have the option to choose another facility for my care.

X_____
Patient or Responsible Part Signature Date