ORANGE COUNTY UROLOGY ASSOCIATES, INC.

A Medical Group

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Patient Name: _____ Birth Date: _____

Last First MI

Sex: *(circle one)* M F Social Security #_____ Drivers License#_____

Address_____ City_____ State_____ Zip_____

Home # _____Cell # _____ Work # _____

E-mail Address _____

Preferred means of communication (circle one) Cell Phone Home Phone Email USPS Mail Any None

Primary Physician_____ | Employer _____

Referring Physician_____ | Occupation _____

Marital Status ***(Circle one)*** **S M D W** | Pharmacy Name_____

Spouse's Name_____ | Phone # _____

Spouse Phone#_____ | Pharmacy *(Street, City)* _____

Emergency Contact **(*other than spouse*)** _____

Relationship to you_____ Phone # _____

Race ***(circle one)*** • African-American/Black • Asian • Asian/Pacific Islander • Chinese • Korean • Native Hawaiian • Native American/Alaskan Native • Vietnamese • White • Other_____ • Decline to State

Ethnicity ***(circle one)*** • Hispanic/Latino • Non-Hispanic/Non-Latino

Language Choice ***(circle one)*** • English • Spanish • Chinese • Tagalog • Vietnamese • Korean • Farsi Other_____

RESPONSIBLE PARTY –If other than self or you are a minor.

Name: _____ Relationship:_____

Address_____ City_____ State_____ Zip_____

Home #_____ Work #_____ S.S. #_____

MEDICAL INSURANCE (please present insurance cards for us to photocopy)

Primary Insurance Company: _____ Subscriber's Name_____

Subscriber's Relationship to Patient _____

Insured's ID#_____ Group #_____ Medicare #_____

Secondary Insurance Company: _____ Subscriber's Name_____

Subscriber's Relationship to Patient_____

Insured's ID#_____ Group #_____ Medicare #_____

PLEASE BE ADVISED THAT YOU WILL RECEIVE SEPARATE BILLS FOR ANY LAB TESTS, X-RAYS, ETC. THAT MAY BE ORDERED FOR YOU, AS THEY ARE DONE BY AN OUTSIDE SOURCE.

Assignment of Benefit-Financial Agreement

Assignment and Release. I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT THEY ARE COVERED BY MY INSURANCE. I hereby assign my benefits to be paid directly to my physician and any assisting physicians. I understand a monthly service fee will be charged on all balance 61 days and older. In the event of default, I agree to pay all costs of collection and reasonable attorney's fees. I authorize this provider to release any information required to process this claim to my insurance company.

Date:_____ Your Signature X_____

THANK YOU FOR YOUR CAREFUL COMPLETION OF THIS IMPORTANT FORM

Revised 8/22/14

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PF-2000 Acknowledgement of Receipt of Notice of Patient Privacy

Orange County Urology Associates, Inc. reserves the right to modify the privacy practices outlined in the notice.

I have received a copy of the Notice of Privacy Practice of Orange County Urology Associates, Inc.

_____ _____

Signature of Patient *Name of Patient* ***(Please Print)***

_____ _____

Date *Patient Date of Birth*

Preferred/Secure Phone Options: ☐ **Yes** ☐ **No**

If yes, Please provide a phone number in which we may leave a message on your voicemail with your personal health information. ❒Home ❒Cell ❒Work

Phone#:_____

Authorized Email Address: To facilitate communication between OCUA and our patients, I give permission to use my email address in a secure online environment. The email communication will be through secure, encrypted messaging. I understand the email address I provide will be used primarily for accessing my patient portal on the OCUA website at www.orangecountyurology.com. It will also be used to contact me for future appointment reminders. Unless I inform OCUA that my email address has changed, OCUA has permission to use the email address below. OCUA will not share this address with any other entity.

Email Address: (Please print clearly) _____

Expanded Medical Release Option: **Please note: This is Valid for 1 Year**

Please list any person(s) you would like to authorize to have access to your billing, appointments or health information.
*** Such as a Spouse, Parents, Family Members, and/or Friends*.

*** With the exclusion of information that is protected under State or Federal law*

Name **Relationship**

_____ _____

_____ _____

Signature of Patient/Representative **Relationship of Patient Representative**

*** Please note that State Federal law provides additional protections for minors and restricts the release of certain patient information to anyone other than the minor*