**Consent for Treatment**

I authorize and consent to the rendering of medical care, including diagnostic procedures and medical treatment by authorized members of Ozark Urology as many in their professional judgment be necessary for the below named patient. I acknowledge that no guarantees have been made as to the effect of such examinations or treatment.

**Assignment of Insurance Benefits**

Patient-Physician Agreement: I, the undersigned, authorize Ozark Urology to release any information acquired in the course of my examination or treatment to my insurance company(s) or another physician. I, recognizing that the medical insurance I possess may not completely cover the fee(s) for professional services rendered me; hereby agree that I am responsible for said fee(s). I authorize payment directly to me for their services. A photocopy hereof shall be valid as the original. I am aware that I may inquire of my physician the fee(s) for any professional services required and/or rendered.

**Authorization to Release Information**

I authorize Ozark Urology to release any information requested by the insurance company necessary to collect benefits under any policy we make claim against for services on this or a related date of service.

**Guarantee of Payment**

I understand that office visits are to be paid for at the time of service unless other arrangements have been made. I understand that I am responsible for the balance not covered by insurance. I understand that Ozark Urology does not accept any insurance policy assignment as a guarantee of full payment.

Patient Signature:

X_____________________________________________________

(Patient or Parent/Guardian if under 18 years of age)

_____________________________________________________

Relationship of Guardian

_____________________________________________________

Date
PATIENT INFORMATION- PLEASE PRINT

SOC SEC #: ______________-____________-_______________          MRN#:___________________
Name: ________________________________________________  Home Phone: _____________________________
   Last          First          Mid Initial
Address: ______________________________________________
City: ____________________________
State: __________ Zip Code: ____________
SEX: □ Male □ Female
Marital Status: □ Married □ Single □ Divorced
□ Partner □ Widowed □ Separated
Date of Birth: _____-____-______ Age: _____ yrs
Employer: ________________________________
Work Address: _________________________
City: ______________ State: ___ Zip: _______
Primary Care Physician: __________________________

REFERRAL
Who referred you to our clinic? (PLEASE CHECK BOX)
□ Washington Regional Medical Center  □ Community or Company Health Fair
□ Newspaper or Magazine  □ Treated by Physician in hospital
□ Recommended by friend or family member  □ Internet
□ Drove by Location of Clinic  □ Phone Directory (Yellow pages)
□ Employer  □ Insurance Plan Directory
□ New Patient/Not Applicable  □ Other: ________________________________

SPOUSE/PARENT INFORMATION
Spouse/Parent Name: _________________________________  Cell: _____________________________________
Employer: _________________________________________  Work: ___________________ Ext: _____________
Work Address: ______________________________________
City: ______________ State: _____ Zip: ____________  Spouse/Parent SEX: □ Male □ Female
Spouse/Parent Date of Birth: _____/_____/_____
Occupation: _________________________________________  Social Sec. #: __________-_______-___________

EMERGENCY CONTACT INFORMATION
Emergency contact: _________________________________  Cell Phone: ________________________________
Address: _________________________________________  Home Phone: _____________________________
City: _______________ State: ______ Zip: ________  Relationship to Patient: _______________________

PRIMARY INSURANCE

Patient’s Relationship to **Main Policy Holder**: □ Myself □ Spouse □ Child □ OTHER: __________________________

Name of Insurance Company: _____________________________________________________________

Insurance Company Address: _____________________________________________________________

City: ___________________________ State: ___________________________ Zip: ___________________

ID# __________________________________ Group # ____________________________________________

Insurance Company’s Phone Number: ___________________________________________________

Main Holder’s Name: __________________________________  Main Holder’s Date of Birth: _____/_____/______

Main Holder’s Address: __________________________________  Main Holder’s Soc Sec#: _______-______-______

City: ________________________________________________

State: _____________________ Zip: ____________________

SECONDARY INSURANCE

Patient’s Relationship to **Main Policy Holder**: □ Myself □ Spouse □ Child □ OTHER: __________________________

Name of Insurance Company: ____________________________________________________________

Insurance Company Address: ____________________________________________________________

City: ___________________________ State: ___________________________ Zip: ___________________

ID# __________________________________ Group # ____________________________________________

Insurance Company’s Phone Number: ___________________________________________________

Main Holder’s Name: __________________________________  Main Holder’s Date of Birth: _____/_____/______

Main Holder’s Address: __________________________________  Main Holder’s Soc Sec#: _______-______-______

City: ________________________________________________

State: _____________________ Zip: ____________________
GENERAL INFORMATION
Who is responsible for Payment?:  □ Myself  □ Other:______________________  (FILL OUT BELOW)

Responsible Party Name: __________________________  Responsible Party DOB: ______/_____/_____

Relationship to Patient:  □ Self  □ Spouse  □ Child  □ OTHER  SS#________________-_______-_________

Address: __________________________________________  Phone#: __________________________

Have you ever been seen as patient at one of our Washington Regional Medical System Clinics?  □ Yes  □ No
If Yes, When?:_________/_________/______ Where?: __________________________________________

RELEASE OF INFORMATION  (spouse, children, parents, etc)

Who may we discuss your information with? For example: Medical issues/care, results, billing, etc.

Name: __________________________________________   Relation to Patient: __________________________
Name: __________________________________________   Relation to Patient: __________________________
Name: __________________________________________   Relation to Patient: __________________________

Preferred Language:  □ English  □ Spanish  □ Marshallese  □ Arabic  □ DECLINE  OTHER:____________________

Race:  □ White  □ African American  □ Asian  □ Native Hawaiian/Other Pacific Islander
□ Native American Indian/ Alaskan  □ Hispanic  □ Unknown  □ DECLINE

Ethnicity (Origin):  □ Not Hispanic or Latino  □ Hispanic or Latino  □ Unknown  □ DECLINE

Preferred Communication Method: □ Print  □ Save to Flash Drive  □ DECLINE

Wellness Reminders: □ Mail  □ Cell Phone  □ Home phone  □ Work Phone  □ DECLINE

PREFERRED PHARMACY:________________________  LOCATION:________________________

I authorize release of any medical information necessary to process my claim to all my insurance companies. I authorize direct payment of medical benefits to the provider. I permit a copy of this authorization to be used in the place of the original. I consent for my photo to be taken. I understand that I am responsible for any amount not covered by insurance. I permit the faxing and electronic transmission of medical information to other health care providers, attorneys, or insurance companies involved in my care. I give my permission for messages to be left on my answering machine or sent by email.
I authorize WRMC operators in their role as an answering service to release my protected health information utilizing the pager system or text messaging. I, the undersigned, authorize and consent to the rendering of medical care, including diagnostic procedures, and medical treatment by authorized members of Washington Regional Medical System or their designees, as may in their professional judgment be necessary for the above named patient. I acknowledge that no guarantees have been made as to the effect of such examinations or treatment. I have received a copy of the Notice of Privacy Practices of the clinic. I permit this facility to obtain my medication history electronically.

X___________________________________________________         Date: _________/__________/________

Signature (Patient or Parent/Guardian if minor)