PATIENT INFORMATION SHEET

PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST

DATE _____

PLEASE PRINT CLEARLY

PATIENT NAME _____ DATE OF BIRTH_____AGE_____SEX___

MARITAL STATUS_____SOCIAL SECURITY NO._____

ADDRESS_____

CITY_____STATE_____ZIP_____

HOME PHONE_____ CELL PHONE _____ CARRIER _____

(required for a text reminder)

EMAIL : _____

REFERRING DOCTOR_____

EMPLOYER_____PHONE_____

ADDRESS_____CITY_____STATE___ZIP_____

SPOUSE (OR PARENT OF MINOR)_____DATE OF BIRTH: _____

SOCIAL SECURITY NO: _____

SPOUSE'S EMPLOYER_____PHONE_____

PERSON TO CONTACT IN CASE OF EMERGENCY_____PHONE_____

Payment is expected at the time service is rendered if there is no insurance to file. We will file insurance for patients who have coverage. Patient will be responsible for any balance that insurance does not cover or if there is no insurance coverage. This is not a guarantee of payment but an estimate. Actual payment and patient responsibility is determined when the claim is processed.

I authorize Georgia Regional Urology, P.C./David L. Perlow, M.D/ Perlow Facility, LLC. to release any and all information regarding diagnosis, treatment, and prognosis with respect to any physical condition and/or treatment of me to my insurance company or its legal representative. Any such disclosure shall be limited to information that is reasonable and necessary for the discharge of the legal or contractual obligations of the insurance company. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim.

I understand that the information obtained by use of this authorization will be used by my insurance company to determine eligibility for benefits under an existing policy. Any information obtained may only be released by my insurance company to any other person or organization as governed by HIPAA or unless I so authorize.

I also authorize payment of all medical benefits to be made payable to David L. Perlow, M.D./Georgia Regional Urology, P.C/ Perlow Facility, LLC. I give my permission to be examined and treated by David L. Perlow, M.D. I agree to the above.

X_____

Signature of Patient or Parent of Minor (**REQUIRED SIGNATURE)** Date

I understand that on rare occasions Dr. David Perlow may not be available or on call. In those situations, an alternative urologist will usually be taking his calls. It is possible, however, that on some occasions neither Dr. Perlow nor a covering physician may be available. In such cases, I understand that I may be directed to the Wellstar Kennestone ER where there is an urologist on call at all times or to another ER.

I have received a copy of Georgia Regional Urology, P.C.'s/Perlow Facility, LLC's Notice of Privacy Practices And Ownership of Practice and Expertise of Physician, Patients' Rights and Responsibilities, DNR Policy, Information Regarding the Grievance Procedure and Information Regarding Our Billing Practice. I have no language, visual or hearing problems which may affect my ability to communicate with the doctor. I understand that Georgia Regional Urology, P.C./Perlow Facility, LLC may communicate with me via, fax, text, voice message or email and that those communications may not be securely encrypted

X_____ _____

Signature of Patient or Guardian (**REQUIRED SIGNATURE**) Date

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IF YOU WISH FOR OUR OFFICE TO DISCLOSE HEALTH INFORMATION TO A FAMILY MEMBER PLEASE INDICATE BELOW:

PERMISSION TO DISCLOSE INFORMATION TO THE FOLLOWING:

NAME _____

ADDRESS _____PHONE _____

SPECIFIC INFORMATION TO BE DISCLOSED:

[ ] ALL RECORDS [ ] OTHER EXPLAIN:
_____

I agree to the above

SIGNATURE OF PATIENT: _____

FILL THIS PORTION ONLY IF THIS IS A WORKMAN'S COMP CLAIM

INSURANCE CARRIER NAME_____ PHONE_____

EMPLOYER AT THE TIME OF INJURY_____ PHONE_____

DATE OF INJURY _____ REPORTED TO _____

CLAIM NUMBER _____ CASE MANAGER _____ Phone _____