ADVANCED UROLOGY of SOUTH FLORIDA

a division of UGF

Lawrence M. Yore, MD, FACS
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5350 W. Atlantic Ave., Ste. 102, Delray Beach

DATE:

NAME	SEX: M ___ F ___	DATE OF BIRTH	AGE	SOCIAL SECURITY NO.
STREET ADDRESS ☐ PERMANENT ☐ TEMPORARY APT #	CITY AND STATE		ZIP CODE	HOME PHONE NO.
PATIENT'S EMPLOYER	OCCUPATION (CURRENT/FORMER)	HOW LONG EMPLOYED?		MOBILE PHONE NO.
EMPLOYER'S STREET ADDRESS	CITY AND STATE			ZIP CODE
SPOUSE'S / PARTNER'S NAME	NUMBER OF CHILDREN AND AGES			MARITAL STATUS S M DP W D
SPOUSE'S / PARTNER'S EMPLOYER	OCCUPATION (CURRENT/FORMER)	HOW LONG EMPLOYED?		BUSINESS PHONE NO.
EMPLOYER'S STREET ADDRESS	CITY AND STATE			ZIP CODE
WHO CAN WE CALL IN AN EMERGENCY, OTHER THAN YOUR HOME PHONE:	E-MAIL:			

INSURANCE INFORMATION

PRIMARY INSURANCE	SECONDARY INSURANCE

GOVERNMENT MANDATED QUESTIONS:

RACE ☐ Caucasian ☐ Afro-American ☐ Hispanic ☐ Asian ☐ American Indian ☐ Alaskan Native ☐ Pacific Islander Other _____

PRIMARY LANGUAGE ☐ English ☐ Spanish ☐ Other _____

ETHNICITY (CHECK APPROPRIATE)

☐ NO, Not Hispanic, Latino, or Spanish Origin ☐ YES, Mexican, Mexican-American or Chicano Origin

☐ YES, Puerto Rican Origin ☐ YES, Cuban Origin ☐ YES, another Hispanic, Latino or Spanish Origin

NORTHERN ADDRESS:

Street: _____ City _____ St _____ Zip _____

Phone _____

I certify that all the above information is accurate. I hereby authorize the release of any information necessary to process my claims. I hereby authorize the release of my medical information to my referring health care provider as well as to those I may be referred to for consultation and/or treatment. Payment of any government benefits may be made either to me or to the party who claims assignment.

I authorize the payment of medical benefits directly to my physician. I am financially responsible for any unpaid balance due. I agree to pay any deductibles, co-insurances and co-pays. I understand that I am financially responsible for any charges not covered by my insurance and if I fail to give updated current information and the claim is denied, I will be responsible for the entire balance.

In the event your check is returned for any reason, your account will be charged $35. If we determine your account should be placed with an outside collection agent or an attorney, you will be assessed an additional 30% of the balance due.

Signed _____ Date _____

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To our patients,

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment.

I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many healthcare professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

I understand that I have the right:

- To object to the use of my health information for directory purposes.
- To request restrictions as to how health information may be used or disclosed to carry out treatment, payment or healthcare operations - and that the organization is not required to agree to the restrictions requested.
- To revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to an address other than your home address.

The physicians and staff of Advanced Urology of South Florida respect your privacy and wish to make all reasonable attempts to respect your wishes regarding your confidential information. With that in mind, please indicate your preferences for the areas noted below.

I wish to be contacted in the following manner (check all that apply)

☐ Home Telephone _____
- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only.

☐ Work Telephone _____
- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only.

☐ Written Communication
- ☐ O.K. to mail to my home address
- ☐ O.K. to mail to my work/office address
- ☐ O.K. to fax to this number: _____

☐ Other individuals (family, friends, etc.) you may speak with about
- ☐ My care of treatment ☐ My bill

Name	Relationship
_____	_____
_____	_____
_____	_____
_____	_____
Print Patient Name	Date of Birth
_____	_____
Patient Signature	Date