UROLOGY CLINIC OF WINCHESTER, P.C. 1712 Amherst Street, Winchester, VA 22601 • (540) 667-1712 • Fax (540) 665-0045

Acct. #: _____ Attending Physician _____ Referring Physician _____ Date: _____

Allergies: _____

PLEASE PRINT **PATIENT INFORMATION**

PATIENT: _____
LAST NAME *FIRST NAME* *MIDDLE NAME*

Address: _____
STREET *CITY* *STATE* *ZIP*

SS #: _____ Sex: ☐ M ☐ F Birth Date: _____ Age: _____ Marital Status: ☐ S ☐ M ☐ W ☐ D

Employer: _____ Bus. Address: _____

Home Phone: (_____)_____ Bus. Phone: (_____)_____ Ext.: _____

In Case of Emergency Notify: _____

Telephone: (_____)_____ Relationship: _____

SPOUSE: _____
LAST NAME *FIRST NAME* *MIDDLE NAME*

SS #: _____ Birth Date: _____ Bus. Phone: (_____)_____ Ext.: _____

Employer: _____ Bus. Address: _____

Please complete the section below if you are not the patient but are responsible for the bill.

RESPONSIBLE PARTY: _____
LAST NAME *FIRST NAME* *MIDDLE NAME*

Address: _____
STREET *CITY* *STATE* *ZIP*

Employer: _____ Bus. Address: _____

Home Phone: (_____)_____ Bus. Phone: (_____)_____ Ext.: _____

Relationship: _____ Patient's or Legal Guardian's Signature: _____

INSURANCE: Your insurance is a method for you to receive reimbursement for fees you have paid to the physician for services rendered. Having insurance is not a substitute for payment. Many companies have fixed allowances or percentages based upon your contract with them, not with our office. It is your responsibility to pay the deductible, co-insurance, and any other balances not paid for by your insurance. We will do all we can to assist you in receiving reimbursement, but you are responsible for your bill. We will file directly with Medicare for you and will accept assignment on the claim. It is your responsibility to pay the deductible, co-insurance, and non-covered services.

Primary Company: _____ Address: _____

Policy #: _____ Group #: _____ Phone: (_____)_____

Subscriber: _____ Relationship to Patient: _____ Insured's Birth Date _____

Secondary Company: _____ Address: _____

Policy #: _____ Group #: _____ Phone: (_____)_____

Subscriber: _____ Relationship to Patient: _____ Insured's Birth Date _____

Workers' Comp. Co.: _____ Address: _____

Date of Accident: _____ Time of Accident: _____ WIC #: _____

I promise to fully and promptly pay all medical fees which I incur to Urology Clinic of Winchester, P.C.
I authorize Urology Clinic of Winchester to release any information acquired in the course of any examination or treatment to any insurance carrier, or to any other person or agency specified by me. Any physician, hospital, or medical care facility is to provide all information regarding my medical history and treatment to Urology Clinic of Winchester.
If I am pursuing a claim against a third party for payment of this account, I hereby assign any and all monies received from this third party, or paid on their behalf, in settlement or termination of my claim against them to Urology Clinic of Winchester, to the extent of the balance due and owing to them as of the date of settlement or other termination of the claim.
In the event that my insurance company should refuse payment of this account for any reason, or should make partial payment on this account.
I hereby agree to be responsible for the outstanding balance on this account.
Execution of this agreement does not release any other person who may be legally responsible for payment of this account, including by other contract, express or implied.
I agree to pay all costs of collection agency and/or attorney's fees of twenty-five per centum (25%) of the outstanding balance, in the event my account is submitted to an attorney-at-law for collection.

_____ _____
(SIGNATURE OF PATIENT OR GUARDIAN *(SIGNATURE OF GUARANTOR – PLEASE SIGN YOUR FULL NAME)*