Andrew L. Simon, M.D., F.A.C.S.
Diplomate, American Board of Urology
Urology and Genitourinary Surgery

PATIENT INFORMATION

Name ______________________________ SS# ____________________
FIRST MI LAST

Mailing Address ______________________________ City ____________________

State ____________ Zip ____________ Date of Birth ____________ Male______ Female ______

Home Phone (_____) ____________________ Work Phone (_____) ____________________

Please check appropriate space: Minor _____ Single _____ Married _____ Widowed_____ Divorced_____

Patient's or Parent's Employer ______________________________

Business Address ______________________________

Spouse or Parent's Name ______________________________

Are you, parent or spouse currently an active member of the military? Yes_____ No _____ If yes, please indicate name, relationship, branch of service ______________________________

Whom may we "thank" for sending you? ______________________________

Allergies ______________________________
DRUGS - FOODS

Person to contact in case of emergency ______________________________

Relationship ____________________ Phone (_____) ____________________

RESPONSIBLE PARTY

Person responsible for this account ____________________ Relationship ____________________

Employer ______________________________ Phone (_____) ____________________

Birthdate ____________ SS# ____________ Work Phone (_____) ____________

INSURANCE INFORMATION

Please give your ***insurance cards*** to our staff so we may make a copy of them.

PRIMARY INSURANCE

Company ______________________________

Insurance Company Address ______________________________

Name of Insured ____________________ Relationship to Insured ____________________

SS# of Insured ____________ ID# ____________ Group ____________

How much is your deductible? ____________ How much have you used this year? ____________

Primary Physician ____________________ Is this a managed care program (HMO)? Yes_____ No_____

Primary Physician's Address ______________________________

Primary Physician's Phone (_____) ____________________ Group Name ____________________

OVER →

Pharmacy Name ______________________________ Phone (____) ________________

Pharmacy Address ____

SECONDARY INSURANCE

Company ____

Insurance Company Address ____

Name of Insured ____________________ Relationship to Insured ____________________

SS# of Insured ________________ ID# ________________ Group ________________

Name of Employer ______________________________ Phone (_____) ________________

How much is your deductible? ____________ How much have you used this year? ____________

Primary Physician ______________________ Is this a managed care program (HMO)? Yes_____ No____

Primary Physician's Address ____

Primary Physician's Phone (_____) ____________________ Group Name ________________

TO OUR PATIENTS:

Our office will attempt to assist you with the completion of your insurance claim. However, each patient, not the insurance company, is responsible for payment to this office. Our office cannot accept responsibility for collecting your insurance claims or for negotiating a settlement on a disputed claim.

Due to the increasing complexity of insurance policies with regard to PRE-CERTIFICATION, ASSISTANT SURGEON, SECOND OPINIONS, etc., for hospital stays and operations, **YOU ARE RESPONSIBLE** for notifying your insurance company before being admitted to the hospital. This will help avoid unnecessary denials or lowering payment for failing to follow the OBLIGATIONS of YOUR POLICY.

We cannot be responsible for any loss of benefits. It is **YOUR RESPONSIBILITY TO KNOW YOUR POLICY.**

Authorization & Release

I, the undersigned hereby authorize payment of medical benefits to Andrew L. Simon, M.D., F.A.C.S., P.A. for any services furnished me by the physician. I understand that I am financially responsible for any amount not covered by my contract.

I authorize release of information concerning my (or my child's) health care, advice, and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

X ____

Signature of patient (or parent if minor) Date

MEDICARE LIFETIME SIGNATURE ON FILE: I request that payment of authorized Medicare benefits be made on my behalf to Andrew L. Simon, M.D., F.A.C.S., P.A. for any services furnished me by the physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or benefits payable for related services.

X ____

Signature PHOTO COPY AS VALID AS ORIGINAL Date