SouthWest Urology
Advanced & Personalized Treatment For Your Entire Family

Last Name _____First_____MI ____ Age _____
Address _____Zip_____ City_____State_____
Name of Parent or Guardian (If patient is a minor) _____
Alternative address for mailing (Optional) _____
Area code - Home Phone: _____Area code - Work phone: _____
Alternate Phone number for calls (Optional) _____ Cell Phone: _____
Email: _____
Preferred Contact Number: □ Home □ Cell □ Other Number _____
I wish to receive reminder/confirmation calls for appointments? YES NO
Social Security # _____Date of Birth _____Gender: □ Male □ Female
Marital Status: □ Single □ Married □ Divorced □ Widowed □ Separated
Employer_____Occupation_____
Family Doctor _____ Phone_____ Fax _____
Referred by_____(If doctor) - Phone _____Fax_____
Reason for visit_____
May we leave a message at your home with other residents? [ ] Yes [ ] No
If you have an answering machine or voicemail, may we leave a message? [ ] Yes [ ] No
If you want your mail sent to an alternate address: _____
_____
Who may we talk to about your medical concerns: _____
Relationship: _____ Home Phone _____ Work Phone _____
Notify in Case of Emergency:
Last Name _____ First_____ Relationship_____
Home phone _____Phone #2_____

NOTICE: SouthWest Urology does not recognize Advanced Directives, DNA (Do Not Resuscitate), and will use all measures possible to sustain life. Resuscitative efforts will be implemented on a patient experiencing a life-threatening only while in the offices of SouthWest Urology.

Payment Authorization/General Consent for Treatment

Medicare and Medicaid: I authorize the release of any medical or other information needed to process any claims on my behalf. I also request payment of government benefits either to myself or to the party who accepts assignment. I authorize payment of medical benefits to Southwest Urology, Inc for services rendered.

All other Insurance Companies an/or Third Party Payers: I HEREBY AUTHORIZE, Southwest Urology, Inc and/or any of its representatives to submit a claim to my insurance carrier or its intermediaries for all services rendered by the physician(s) and other health care professionals and authorize and direct my insurance carrier or its intermediaries to issue payment directly to Southwest Urology, Inc for rendering services. I authorize the release of any medical or other necessary information to my insurance carrier or its intermediaries regarding services rendered.

Guarantee of Payment: I understand that filing a claim with my insurance company or other third party payers, under any circumstances, does not relieve me from my responsibility for the payment of all charges. I further acknowledge that I am responsible for the payment of all charges for services rendered by Southwest Urology, Inc to me or to the patient as indicated. By signing this document, I personally guarantee the payment of these charges for medical services rendered. This includes, but is not limited to, claims filed for Worker's Compensation and /or claims due to personal injury, accident/illnesses.

General Consent to Treatment: Having come to Southwest Urology for evaluation or treatment, I (or my authorized representative on my behalf) hereby consent to and authorize the Physicians and other staff members involved in my care to administer such diagnostic procedure, treatment or both as they may consider advisable to maintain my health and to assess and to evaluate and treat my injury or illness. I understand that the provider responsible for my care has the responsibility to explain to me the purpose, the benefits and the most common risks involved in the diagnosis and treatment of my illness or injury, as well as alternative available courses of treatment, and I understand that I have the right to refuse any suggested examination, test or treatment. Right to refuse treatment: In giving my general consent to treatment, I understand that I retain the right to refuse any particular examination, test, procedure, treatment, therapy or medication recommended or deemed medically necessary by my individual treating health care providers. I also understand that the practice of medicine is not an exact science and that no guarantees have been made to me as to the results of my evaluation and/or treatment.

_____ _____
Signature **Date Signed**