

SUNCOAST UROLOGY, P.A.

7614 Jacque Road
Suite A
Hudson, Florida 34667
(727) 862-8548

Barry T. Sadler, M.D.
Kevin S. Spires, M.D.
Arnie B. Tannenbaum, M.D.

11373 Cortez Boulevard
Suite 208
Brooksville, Florida 34613
(352) 596-0786

Welcome to Suncoast Urology. You have an appointment scheduled on

_____, with Dr _____.

Please inform your referring physician of this appointment and ask the office to send records. We will need all lab reports, X-ray reports, and the films of any X-rays that you may have had, that are pertaining to your appointment. If we do not have this information at the time of your appointment it may have to be rescheduled.

Thank you for your attention to this and if you have any questions please call us at 727-862-8548 or 352-596-0786.

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PATIENT INFORMATION

NAME _____
(last) (first) (middle)

LOCAL ADDRESS: _____

CITY-STATE-ZIP: _____ PHONE: _____

Sex: M F Marital Status: S M D W Date of Birth: _____ Age: _____

SOCIAL SECURITY NUMBER: _____

Referring Dr.: _____ Family Dr.: _____

Northern Address: _____

City-State-Zip _____ Phone: _____

Previous/Present Employment: _____ Phone: _____

Spouse's Name: _____ Spouse's Employer _____

INSURANCE INFORMATION

Primary Insurance: _____

Policy Holder (if different than patient) _____

Insurance Address: _____

City-State-Zip: _____

ID Number and/or Group Number: _____

Other Insurance: _____

Policy Holder (if different than patient) _____

Insurance Address: _____

City-State-Zip: _____

ID Number and/or Group Number: _____

IN CASE OF EMERGENCY NOTIFY: (other than someone living in household)

Name: _____ Phone: _____

Signature: _____ Date: _____

SUNCOAST UROLOGY

LIFETIME AUTHORIZATION, INSURANCE ASSIGNMENTS AND AUTHORIZATION TO RELEASE INFORMATION

- I. TREATMENT AUTHORIZATION** – I, the below named patient, do hereby give Suncoast Urology consent for medical treatment.
- II. RELEASE OF INFORMATION** – I do hereby authorize any physician of this group examining and/or treating me to release to any third party payor (such as an insurance company or governmental agency, i.e., Medicare, Medicaid), any medical condition and records concerning diagnosis and treatment when requested by such third party for its use in connection with determining a claim for payment for such treatment and/or diagnosis.
- III. PHYSICIAN INSURANCE ASSIGNMENT** – I hereby authorize payment directly to any physician of this group examining or treating me any surgical and/or medical benefits herein specified and otherwise payable to me for their services and described but not to exceed the reasonable and customary charge for these services.
- IV. MEDICARE/MEDICAID** – **Patient’s certified authorization to release information and payment request.** I certify that the information given by me in applying for payment under Title XVII/XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to Social Security Administration/Division of Children and Families or its intermediaries or carriers any information needed for this or a related Medicare/Medicaid claim. I hereby certify all insurance pertaining to treatment shall be assigned to the physician treating me.
- V. I PERMIT A COPY OF THESE AUTHORIZATIONS AND ASSIGNMENTS TO BE USED IN PLACE OF THE ORIGINAL, WHICH IS ON FILE AT THE PHYSICIAN OFFICE.** This assignment will remain in effect until revoked by me in writing.

We are committed to providing you with the best possible care. If you have medical insurance, we will be glad to help you receive your maximum benefits. In order to achieve these goals, we need your assistance and understanding of our payment policy.

Your insurance is an agreement between you and the insurance company- not an agreement between the doctor and the insurance company. As the patient, you further understand that you are ultimately responsible for the charges for medical care being rendered to you.

Our fees are generally considered to fall within the acceptable range by most companies. Our fees are considered **USUAL, CUSTOMARY AND REASONABLE** by most insurance companies.

We bill all Medicare claims as well as PPO, HMO and managed care plans that we participate with. Patients will be asked to pay all deductibles and co-pays at time of service. It is also the patient’s responsibility to obtain all referrals and/or authorization numbers as required by their insurance plan. Changes in your insurance coverage must be given to the receptionist prior to your appointment.

PATIENT NAME

PATIENT SIGNATURE

GUARANTOR NAME

GUARANTOR SIGNATURE (IF OTHER THAN PATIENT) DATE

LIFETIME AUTHORIZATION, MEDIGAP (SECONDARY INSURANCE) SIGNATURE

PATIENT NAME

HEALTH INSURANCE COMPANY

POLICY NUMBER

I request that payment of authorized MEDIGAP/Secondary Insurance benefits be made on my behalf to Suncoast Urology for any services furnished me by Suncoast Urology. I authorize any holder of medical information about me to release to

(MEDIGAP/SECONDARY INSURANCE CO) any information needed to determine benefits or the benefits payable for related services

PATIENT SIGNATURE

DATE

SUNCOAST UOLOGY
HIPPA MEDICAL RELEASE INFORMATION

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY!

Please list names of any person(s) whom we may inform about your general medical Condition and your diagnosis (including treatment, payment and healthcare operations).

Please indicate if you want correspondence from our office sent in a Sealed envelope marked "Confidential". YES _____ NO _____

Can confidential messages (i.e. appointment reminders, lab results, etc) be Left on answering machine or voice mail. YES _____ NO _____

PATIENT NAME _____

PATIENT OR GUARDIAN SIGNATURE _____

DATE _____

We are required by Law to maintain the privacy of your personal health Information, and to provide you notice of our legal duties and privacy Practices and adhere to this notice. We reserve the right to make changes To this notice. We will post a notice that the notice has been changed and The effective date of this change, copies will be made available.

If you receive no resolution to your complaint, you can send a written statement to this office or the Secretary of Health and Human Services.

SUNCOAST UROLOGY, P.A.

REQUEST FOR RELEASE OF MEDICAL RECORDS

To: _____

Fax: _____

PHONE: _____

I hereby request that medical records be released to:

Barry T. Sadler, M.D.

Kevin S. Spires, M.D.

Arnie B. Tannenbaum, M.D.

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Hudson, FL 34667
(727) 862-8548

11373 Cortez Blvd. Suite 208
Brooksville, FL 34613
(352) 596-0786

Fax: (727) 863-4530

Date _____

Patient Name  _____

Patient Signature  _____

Date of Birth _____

Social Security Number _____