PLEASE FILL OUT COMPLETELY AND BRING TO YOUR APPOINTMENT

2351 Connecticut Ave South
Suite 200
Sartell MN 56377

Ph: 320-259-1411
fax: 320-259-8967
www.apumn.com

John K. Matsuura, M.D.
Jerome P. Keating, M.D.
Gregory S. Parries, M.D., Ph.D.
Christopher W. Boelter, M.D.
Henri P. Lanctin, M.D.
Keegan L. Maxwell, M.D.
Shawn M. McGee, M.D.
John M. Wolfe, C.U.P.A.
Gayle C. Leen, C.U.P.A.
David P. Buhl, P.A.-C.
Megan A. Rose, P.A.-C.

Patient Legal Name:____
(Last) (First) (M.I.)

Patient Address: ____
(Street/PO Box) (City) (State) (Zip)

Patient Numbers: Home (______)__________________ Work (______)__________________ Cell (______)__________________

Patient Date of Birth____/____/____ Age:____ Sex: M / F Marital Status M / S / D / W Patient Social Security No: ____________________

Referred by: ______________________________________ Clinic: ______________________________________

Family Physician: ______________________________________ Clinic: ______________________________________

Pharmacy:______________________________________ Nursing or Group Home: __________________ ____________

IMPORTANT who can be given information: ______________________________ ph: ____________________________

(name and relationship) ______________________________ ph: ____________________________

Responsible Party: ____ Phone No: ______________________________

PRIMARY INSURANCE

Insurance Company Name:______________________________ Address:______________________________________

Policy #: ____ Group #: ______________________________________

Subscriber Name: ____ Relationship:____________________

Birth date:__________________________ Soc Sec #:______________________________

SECONDARY INSURANCE

Insurance Company Name:______________________________ Address:______________________________________

Policy #: ____ Group #: ______________________________________

Subscriber Name: ____ Relationship:____________________

Birth date:__________________________ Soc Sec #:______________________________

FINANCIAL AGREEMENT

I certify that I am the patient or that I am financially responsible for the services rendered and do hereby unconditionally guarantee the payment of all amounts. Payments are due upon receipt of the first statement. A finance charge of .66% (7.92 APR) will be applied each month on all outstanding balances over 60 days. Facility employees are NOT able to define your insurance coverage. If you have coverage questions, you are advised to call your insurance carrier. Adult and Pediatric Urology's written financial policy is available on our website or upon request.

ASSIGNMENT OF BENEFITS

I hereby assign to and authorize payment directly to Adult & Pediatric Urology of all benefits due me and/or dependents under Medicare, Medicaid, or any insurance policy providing benefits for facility charges, for services rendered by the facility/physician/supervisor.

RELEASE OF RECORDS

I irrevocably agree that the facility may disclose, to the extent allowed by the law, my medical and financial record to any affiliate of the facility, specifically including (a) my referring and/or family physician, (b) any physician treating, consulting, or otherwise performing services for me, including his or her employees and agents, (c) insurance companies including Centers for Medicare and Medicaid Services, the Health Care Financing Administration and its agents, if applicable to determine those benefits payable for related services, any other governmental or accrediting agency, or their agents or employees, (d) the responsible party, (e) the person(s) I have listed above, and (f) myself.

__________________________________ __________________
Patient/Guarantor Date

PRIVACY PRACTICE ACKNOWLEDGEMENT

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. These rights are more fully described in Adult & Pediatric Urology's Notice of Privacy Practices. Adult & Pediatric Urology is permitted to revise its Notice of Privacy Practices at any time. We will post the current notice at our facility, on our website, and have copies available for distribution. We will provide you with a copy of the revised Notice of Privacy Practices upon your request. The undersigned acknowledges receipt of this information.

A photostatic copy of this agreement shall be considered effective and valid as the original.

☐ **Accepted Copy** ☐ **Rejected Copy** __________________________________ __________________ **rev.02/2009**
Patient/Guarantor Date