Patient Information	Name (Last, First, MI)			Today's Date
Street Address (if PO Box also give physical home address) APT#___			Marital Status □ Single □ Married □ Divorced □ Widowed □ Separated	
City	State	Zip	Gender □ Male □ Female	Date of Birth
Social Security #	Home Phone	Work Phone	Cell Phone	Primary Language
Occupation	Employer Name and Address			If Student □ Full Time □ Part Time
□ American Indian/Alaska Native □ Asian □ Black/African American □ Nat Hawaii/ Pac Islander □ Other □ White				
□ Hispanic/Latino □ Not Hispanic	Pharmacy (Name Address and Telephone Number)			
Email:_____ by providing this email I consent to release of my personal health information via patient portal				
Insurance Information	Please give your insurance cards, drivers license or picture ID to the receptionist to copy			
Name of Primary Insurance Company □COBRA Plan			Policy #	Group #
Please indicate the policy holder for the primary insurance □ self □ spouse □ parent □ other _____				
Name of Secondary Insurance Company □COBRA Plan			Policy #	Group #
Please indicate the policy holder for the secondary insurance □ self □ spouse □ parent □ other _____				

Spouse or Parent	Emergency Contact	Referral Information How did you hear about us?
Spouse or Parent Name _____ In case of emergency, we may contact the person □ Yes □ No	Name_____ Phone:_____ Relationship to patient_____	□ Practice website- www.urologycenternj.com □ Google Search □ Yahoo/ MSN/Bing Search □ Web Blog □ Other web site_____ □ Friend or relative □ Physician Name_____ □ Health Ins Plan or directory
Spouse or Parent Date of Birth (Required if covered by their insurance)	Your Primary Care Physician Name_____ Address_____ Phone_____	
Spouse or Parent Employer (Required if covered by their insurance)	Your Referring Physician Name_____ Address_____ Phone_____	

ASSIGNMENT OF BENEFITS/ RELEASE OF INFORMATION and ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND FINANCIAL POLICY

Assignment of Benefits and Release of Information: By signing below, I hereby irrevocably assign to you, my medical provider, all of my rights and benefits under my insurance contract for payment for services rendered to me, including but not limited to all my rights under "ERISA" applicable to the medical services at issue. I authorize you to file insurance claims on my behalf for services rendered to me and this specifically includes filing arbitration/litigation in your name on my behalf against the health care carrier. I irrevocably authorize you to retain an attorney of your choice on my behalf for collection of your bills. I authorize and consent to your acting on my behalf in this regard and in regard to my general health insurance coverage and I specifically authorize you to pursue administrative appeals conducted pursuant to "ERISA". I assign all insurance benefits to which I am entitled including Medicare and/or any other insurance or health plans to NJ Urology and/or UCE. Consent to Treat: I give my consent for treatment for the care of the patient indicated and for UCE employees or associates to leave messages on my answering machine or voice mail regarding my medical care, test results, appointment confirmations and payment issue. Charges for laboratory testing services (e.g. specimen, tissue, blood or bodily fluids) are not included in physician fees and are separate from any payments made to our doctor. NJU will submit a claim to your insuance for any laboratory test performed at our office. I hereby consent to pathology billing. Financial Policy I understand that be signing below, I agree to abide to the financial policy described herein. I am financially responsible for all charges including any copay, deductible, non-covered service or any charges not paid by the insurance company. I understand that if my insurance requires a referral or precertificaton and I do not have the same, I will be responsible for the charges. Copayments, deductible, non covered charges and past due balances are due at the time of service. I understand it is my responsibility to inform this office if there is a change in my health insurance. Payment in full will be due at the time of service if I do not have insurance, if this office does not participate in my plan or if the services are not covered under my plan. Notice of Privacy Practices Acknowledgment By signing below, I acknowledge that I have been provided a copy of the Notice of Privacy.

X_____ Date:_____

Signature of Patient or responsible Party