BLUE RIDGE UROLOGY

402 Memorial Drive Extension Greer, SC 29651

54 Hospital Drive, Ste. 3B Columbus, NC 28772

**Patient's Last Name**_____ First _____Initial ____ Age _____

**Date of birth** _____ SS # _____ Male _____ Female _____

Marital Status: Married _____Single _____Divorced _____Widowed _____

Address _____City _____St. _____Zip _____

Mailing Address _____City _____St. _____ Zip _____

Home Phone_____Work Phone_____ Cell _____

Email Address _____Cell Phone Carrier _____

Are you employed Yes _____ No_____ Full Time _____ Part Time _____Retired _____

Place and address employment_____

Spouse or significant other's Name _____

Emergency contact _____Relationship _____Phone#_____

Referring Physician _____

INSURANCE INFORMATION –PRIMARY

Plan name _____Policy # _____ Group # _____

Cardholder's Name _____ Cardholder's Relationship _____

Cardholder's DOB _____ SS# _____

Employer _____ Work Phone _____

PLEASE TURN PAGE OVER

## INSURANCE INFORMATION – SECONDARY

Plan Name _____ Policy#_____ Group# _____

Cardholder's Name _____ Cardholder's Relationship _____

Cardholder's Date of Birth _____ SS#_____

Employer _____Work Phone _____

## MINOR PATIENT'S ONLY

Father's Name _____ Phone _____

Father's Employer _____ Employer's Phone _____

Mother's Name _____ Phone _____

Mother's Employer _____ Employer's Phone _____

Custodial Parent/Guardian _____ Phone _____

Custodial Parent/Guardian Employer _____ Phone _____

## NO INSURANCE COVERAGE

I DO NOT HAVE INSURANCE COVERAGE. I UNDERSTAND THT I AM RESPONSIBLE FOR FULL PAYMENT AT THE TIME OF SEVICE. NO BALANCES WILL CARRIED OVER UNLESS DISCUSSED BEFORE APPOINTMENT.

Patient's Signature _____Date _____

## DISCLAIMER

IF WE ARE A PARTICIPATING PROVIDER WITH YOUR INSURANCE COMPANY, YOU ARE, BY FEDERAL LAW RESPONSIBLE FOR ANY ALLOWABLE CO-PAYS OR DEDUCTIBLES. IF WE HAVE A SIGNED CONTRACT WITH INSURANCE CO., WE CAN NOT WAIVE COPAYS OR DEDUCTIBLES.
**AUTHORIZATIONS OR REFERRALS ARE NOT A GAURANTEE OF PAYMENT, CARD HOLDER IS RESPONSIBLE FOR PAYMENT.**

I AUTHORIZE BLUE RIDGE UROLOGY TO RELEASE TO MY INSURANCE COMPANY ANY INFORMATION REQUIRED FOR PAYMENT TO BE AUTHORIZED. I REQUEST THAT PAYMENT OF INSURANCE BENEDITS BE ASSIGNED TO BLUE RIDGE UROLOGY. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL FEES REGARDLESS OF INSURANCE COVERAGE.

PATIENT'S SIGNATURE _____ DATE _____