MERRIMACK UROLOGY ASSOCIATES, P.C.

Date_____

Patient Name _____ _____ ___ Date of Birth ____/____/____
Last Name First Name M.I.

Street Address _____ City _____ State _____Zip _____

Home Phone_____ Cell Phone_____ Work Phone_____

Primary Care Physician _____ Address _____

Pharmacy: _____Address _____ Mail Order Pharmacy_____

E-MAIL :_____ to allow us to web-enable you

Marital Status: S M W D (Circle one) **Gender**: M F Transgender (Circle one)

Preferred Language: _____

Ethnicity: Hispanic origin ☐ Not of Hispanic Origin ☐

Race:
American Indian or Alaska Native ☐
Asian or other Pacific Islander ☐
Black or African American ☐
White ☐
other ☐

Merrimack Urology Assoc., P.C., has my permission to:

☐ Leave a message on cell phone.
☐ Leave a message at work.
☐ Leave a message on answering machine
☐ Leave a message on voicemail
☐ Send reminder message by email

The physicians/staff of Merrimack Urology Assoc., P.C. has my permission to discuss my medical condition and/or history with:

Emergency contact Name: _____**Relationship:**_____

Phone:_____

Or Name: _____**Relationship:**_____

Phone:_____

*****You must notify us if you wish to change your permission form*****

Patient Signature_____Date_____

Insurance Information: (*Copies of <u>all</u> your insurance cards are required)*

<u>Primary Insurance</u>

Insurance Company_____ Subscriber ID: _____

Subscriber Name _____Date of Birth _____Relationship: (S)elf (W)ife (H)usband (C)ild

<u>Secondary insurance</u>

Insurance Company_____ Subscriber ID: _____

Subscriber Name _____Date of Birth _____Relationship: (S)elf (W)ife (H)usband (C)ild

<u>For All Insurances</u>

I hereby authorize Merrimack Urology Associates, P.C. to furnish information to my insurance carrier in the course of my treatment, and further authorize payment of surgical and/or medical benefits to the physicians. In consideration of medical services to be rendered, I understand that I am responsible for any unpaid balances, including co-payments, co-insurance and/or deductibles, and payment is due within ten (10) days of the billing date. In the event that legal action is necessary to collect my debt. I agree to pay the costs of collection plus any reasonable attorney's fees and court costs necessary for its collection.

If I do not keep my scheduled appointment or cancel my scheduled appointment within 24 hours of my appointment I understand and agree that Merrimack Urology Associates will ***charge my account a $50.00 fee.*** I further authorize the release of any medical information necessary to process this or related claims. I also request payment of government benefits to the party who accepts assignment. I permit a copy of this authorization to be used in place of the original.

If I am a member of a managed care health plan or if my insurance company requires a referral, I understand I have an obligation to obtain a referral from my primary care physician. If a referral is not obtained or denied, I will be responsible for payment of services.

I acknowledge that I have received the Notice of Privacy Practices.

I understand and authorize that if my physician needs to take a biopsy, or collect a fluid specimen, the specimen/s may be sent to an outside lab that Merrimack Urology Associates, P.C. works with for samples and slide preparation. Results of these tests require interpretation by a pathologist – a physician who specializes in laboratory medicine. This will generate a pathology report. As with laboratory tests, pathology and lab services may be billed separately from our office or in conjunction with our office. I authorize Merrimack Urology Associates, P.C. to provide a copy of my insurance or billing information with the specimen when it is sent to the lab. The lab companies that we use participate in most insurance plans. However, some insurance companies may exclude the laboratories that we work with from their networks. Please check with your insurance provider to find out if any co-payments or deductibles may apply to these laboratory services.

Signature: _____ Date: _____

Patient Name: _____ **Date of Birth** _____

(Please Print)

Please bring a complete list of your home medications with you to every appointment so we can review your current medications with you. You may use this list or bring your own.

Do you take an Aspirin or Baby Aspirin routinely? Yes No

Do you have any medication allergies? Yes No

If yes, please list these medications:

_____

_____

_____

Do you take any medications at home? Yes No

(Including over the counter medications i.e. herbal supplements, cold medicines, vitamins/minerals, and dietary supplements)

If yes, please list these medications below:

Medication Name	**Dose** ***(how much)***	**How do you take it** ***(by mouth, patch, injection, inhaler, drops, ointment)***	**Frequency** ***(how often)***	**Physician who prescribed the medication**
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				

David J. Berman, M.D., F.A.C.S.
Richard E. Altman, M.D.
Robert A. Edelstein, M.D., F.A.C.S.
Matthew A. Cohen, M.D.
David W. Shi, M.D.
Corinne Puzio, M.D.
George T. Klauber, M.D.
Marcelle F. Saurman, NP-C

Acknowledgment and Consent

By signing below, I acknowledge that I have been provided a copy of this Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by the medical group listed at the beginning of this notice, and how I may obtain access to and control of this information. Finally, by signing below, I consent to the use and disclosure of my health information to treat me and arrange for my medical care, to seek and receive payment for services given to me, and for the business operations of the medical group, its staff, and its business associates.

_____
Signature of Patient or Personal Representative

_____
Print Name of Patient or Personal Representative

_____
Date

_____
Description of Personal Representative's Authority

David J. Berman, M.D., F.A.C.S.
Richard E. Altman, M.D.
Robert A. Edelstein, M.D., F.A.C.S.
Matthew A. Cohen, M.D.
David W. Shi, M.D.
Corinne Puzio, M.D.
George T. Klauber, M.D.
Marcelle F. Saurman, NP-C

Medication History Consent Form

Merrimack Urology Associates, P.C. requires your consent to access your medication history from pharmacies and pharmacy benefit managers. Accessing your medication history assists us in verifying your medication list for purposes of your treatment.

I hereby authorize Merrimack Urology Associates, P.C. to access my medication history from pharmacies or pharmacy benefit managers.

DATE_____

Patient Name _____ Date of Birth_____

Patient Signature _____

Legal Guardian Name (please print) _____

Legal Guardian Signature _____