❑ Vick

Patient's Last Name: _____

Patient's First Name: _____ Middle Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____ Sex: M F

Employer's Name: _____ Occupation: _____

Employer's Address: _____

Home Telephone: (____) _____ Work Telephone: (____) _____

Cell Telephone: (____) _____ Pager: (____) _____

Date of Birth (Month/Day/Year): _____ Age: _____

Social Security Number: _____

Marital Status: Single Married Widowed Divorced Separated

Referred to this office by: _____

PRIMARY INSURANCE INFORMATION

Carrier: _____

Address: _____

City, State, Zip: _____

Telephone: _____

Insured Name: _____

Insured Date of Birth: _____

Relation to Insured: ❑ Self ❑ Spouse ❑ Child

ID/SS Number: _____

Group Number: _____

Group/Company Name: _____

SECONDARY INSURANCE INFORMATION

Carrier: _____

Address: _____

City, State, Zip: _____

Telephone: _____

Insured Name: _____

Insured Date of Birth: _____

Relation to Insured: ❑ Self ❑ Spouse ❑ Child

ID/SS Number: _____

Group Number: _____

Group/Company Name: _____

WORKMAN'S COMPENSATION CLAIMS - Date of Injury: _____

Spouse's Name: _____ Work Telephone _____

Spouse's Social Security Number: _____ Date of Birth _____

In Case of Emergency Contact: _____ Telephone _____

The undersigned hereby authorized the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits for services rendered, or for services to be rendered without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

Signature _____ Date _____

Urology Consultants, PA
Sammy Vick, MD

Patient: _____ Date of Birth: __/__/__ Acct #: _____

Home #: ( ) _____ Cell Phone: ( ) _____

Pharmacy: _____ Pharmacy #: ( ) _____

PCP: _____ PCP #: ( ) _____

Medical/Allergy Alerts:	

Surgical History	Medication List

Date	Pharmacy Refills

Sammy Vick, MD
Urology Consultants, PA
8043 Wurzbach, Ste 615
San Antonio, Tx 78229
210-616-0410 Office
210-615-1295 Fax

No Show Acknowledgement

Patient Name: _____

Date Of Birth: _____/_____/_____

I authorize **Urology Consultants, PA.**

To charge my credit card for the balance on my account, fees not paid by my insurance or if I should have a return check.

There will be a $25.00 fee for a NO SHOW and NO CALLING WITHIN 48 hours of your appointment to cancel. If you have a medical emergency the fee will not be charged. There will be a $150.00 cancel fee for not showing for surgery and not calling to cancel.

Card Holder Name: _____

Credit Card Number: #_____

Type of Credit Card : _____ Zip Code: _____

Security Code located on the back of the credit Card : _____

Exp. Date: _____

Patient Signature: _____ Date: _____

Note: If you do not have credit card information to release you will be billed the fee and additional finance charges may apply.

*I have read the above information and I do not have credit card information to release.

Patient Signature:_____ Date: _____

Urology Consultants, P.A.
8038 Wurzbach, Suite 430
San Antonio, Texas 78229
210-616-0410

Notice of Privacy Practices

To our patients: This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

We realize that these laws are complicated, but we must provide you with the following important information:

Use and disclosure of your health information in certain special circumstances

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For Workers Compensation and similar programs.

Your rights regarding your health information

1. Communications: You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to Urology Consultants, P.A., 8038 Wurzbach, Suite 430, San Antonio, TX 78229 (210) 616-0410.
4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to Urology Consultants, P.A. 8038 Wurzbach, Suite 430, San Antonio, TX 78229 (210) 616-0410. You must provide us with a reason that supports your request for amendment.
5. Right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this notice, contact our front desk receptionist.
6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact Urology Consultants, P.A., 8038 Wurzbach, Suite 430, San Antonio, TX 78229 (210)616-0410. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
7. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies, please contact Urology Consultants, P.A., 8038 Wurzbach, Suite 430, San Antonio, TX 78229, (210) 616-0410).

I hereby acknowledge that I have been presented a copy of Urology Consultants, P.A., Notice of Privacy Practices.

Signature _____

Date _____

Name of Patient _____