INSURANCE INFORMATION AND ASSIGNMENTS

Name of Primary Insured if other than yourself:_____

Primary Insured Date of Birth: ____/____/_____ SSN: _____

Please attach front and back photocopies of your insurance card.

Provider Name: _____

Group #: _____ Subscriber ID: _____

As a courtesy we will bill your primary insurance and secondary insurance companies if you provide us with a copy of your insurance card(s).

ALL co-pays will be collected for each office visit at **check-in**. A $35.00 fee will be assessed for all returned unpaid checks made payable to this office. I hereby authorize North Coast Urology Medical Associates, Inc. to furnish information to insurance carriers concerning my illness and treatments and I hereby assign to North Coast Urology Medical Associates, Inc. all payments for medical and surgical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance.

Patient Signature: _____ Date: ____/____/_____

Insured Signature: _____ Date: ____/____/_____

A photocopy of this authorization and alignment shall be considered as valid as the original.