Johanna C. Figueroa, M.D.
216 Mineola Ave/ Willis Ave
Roslyn Heights, NY 11577

Urology and Pelvic Health
Tel #: (516) 399-2501
Fax #: (516) 399-2504

PATIENT INFORMATION:

PATIENT NAME: _____

STREET ADDRESS: _____ APT#: _____

CITY: _____ STATE: _____ ZIP: _____

SEX: M____ F____ DATE OF BIRTH: _____ SSN #: _____

HOME #: (_____) _____ CELL #: (_____) _____

WORK #: (_____) _____ MARITAL STATUS: _____

IN CASE OF AN EMERGENCY: NEXT OF KIN: _____

RELATIONSHIP: _____ TEL#: (_____) _____

DOCTOR INFORMATION:

NAME OF PCP OR REFERRING DOCTOR: _____TEL #: (_____) _____

INSURED INFORMATION:

NAME OF INSURED PATIENT: _____D.O.B. OF INSURED PATIENT: _____

PRIMARY INSURANCE: _____ POLICY #:_____ GROUP #: _____

TEL #: (_____) _____ IS INSURED A? PATIENT _____ OTHER _____

RELATIONSHIP TO INSURED: _____ D.O.B. OF POLICY HOLDER: _____

NAME OF POLICY HOLDER: _____ SSN #: _____

SECONDARY INSURANCE: _____POLICY #:_____ GROUP #: _____

TEL #: (_____) _____ IS INSURED A? PATIENT _____ OTHER _____

RELATIONSHIP TO INSURED: _____ D.O.B. OF POLICY HOLDER: _____

NAME OF POLICY HOLDER: _____ SSN #: _____

SIGNATURE: _____ DATE: _____

Assignment of Benefits to Urology and Pelvic Health

Patient Name: _____
Insurance Name: _____
TEL#: (_____) _____**S.S.N. #:** _____
I request that payment of authorized benefits be made on my behalf to:

Urology and Pelvic Health
216 Willis Ave Suite #001 (Lower Level)
Roslyn Heights, NY 11577

For services furnished to me by the providers of Urology and Pelvic Health. I authorize Urology and Pelvic Health to release appropriate information, medical or otherwise, as provided for by the HIPAA Privacy Rule, to my insurance carrier and/or Centers for Medicare and Medicaid Services and its agents as needed to determine those benefits payable for related services.

This is a direct assignment of my rights and benefits under this policy.

This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

(Check each box and sign at the bottom.)

- ☐ A photocopy of this Assignment shall be considered as affective and valid as the original.
- ☐ I authorize the release of any medical or other information pertinent to my case to any insurance company, adjuster, or attorney involved in this case for the purpose of processing claims and securing payment of benefits.
- ☐ I authorize the use of this signature on all insurance submissions.
- ☐ I authorize Urology and Pelvic Health to deposit checks made in my name.
- ☐ I authorize Urology and Pelvic Health to initiate a complaint to the insurance Commissioner for any reason on my behalf.
- ☐ **I understand it is my responsibility to provide Urology and Pelvic Health current and accurate information regarding my medical insurance coverage and referrals when necessary from my primary care physician. I understand failure to do so could result in non-payment by insurance carrier and that any such balances are my responsibility. I understand that I am financially responsible for all charges if not paid by insurance company.**
- ☐ **I understand that I do not have secondary insurance and will be responsible for all monies not paid by primary insurance company.**

I understand that Urology and Pelvic Health is compliant with HIPAA's Privacy Rule and that they adhere to the rules and regulations with regard to my medical records, or Protected Health Information (PHI). I consent to my PHI being used, disclosed and obtained as described in the Notice of Privacy Practices currently in effect.

I authorize Urology and Pelvic Health to leave messages on my answering machine at home as needed to notify me of appointments or changes in any of the upcoming visits.

_____ _____
Signature of policyholder **Date**