

The Urology Group

Walter M. O'Brien, MD; Kevin P. O'Connor, MD; Nicholas G. Lailas, MD; Gregory S. Schenk, MD;
Darlene M. Gaynor-Krupnick, DO; Julie Spencer, DNP, FNP-BC, CUNP;
Kristin Tamburro, FNP-BC; Kathleen Cage, FNP-BC

Today's Date _____ Please Print Clearly

Patient Name(First) _____ (MI) ____ (Last) _____

Address _____

City _____ State _____ Zip _____

Sex M F Marital Status M S D W Student Y N SSN _____

Race _____ Ethnicity _____

Preferred Language _____

Home Phone _____ Cell Phone _____

Work Phone _____ DOB _____ Age _____

Patient Employer _____ Job Title _____

Address _____

Who Referred You to This Practice _____

Primary Care Physician (1st/last name) _____ Phone _____

Please be advised. We cannot give information to anyone without your written consent.
I authorize The Urology Group to speak with the person(s) listed below regarding my medical care.

1. _____

2. _____

Authorized person/
My Emergency Contact

Relationship to Patient

Phone Number

I authorize The Urology Group to leave a voice mail message at the following number(s). Messages may at times include some protected health information, including appointment reminders, test results and instructions. I understand that with my signature I am authorizing the release of oral communication by The Urology Group to this voice mail number(s).

Home _____ Cell _____ Work _____

Signature _____ Date _____

Page 2

Name _____ DOB _____

Primary Insurance _____

ID # _____ Group # _____

2nd Insurance _____

ID # _____ Group _____

If the Insurance is in someone else's name please complete

Name of Insured _____ Relationship to Patient _____

Address _____

Phone _____ SSN _____ DOB _____

Insured's Employer Name/Address _____

Minor/Child Responsible Party Information

Name _____ Relationship _____

Address _____

Home Phone _____ Work Phone _____

Employer _____ SSN _____

I authorize my insurance benefits to be paid directly to the physician and I am financially responsible for all charges. I hereby consent to the release and re-disclosure of my medical record to enable or facilitate the collection, verification or settlement of my account for any amounts due from me or my third party payer, health maintenance organization, insurer or other health benefit plan. This consent and authorization applies to LMG, PC/The Urology Group.

I agree to promptly pay for services rendered for me or the patient named above. If I fail to meet my financial commitment to LMG, PC/The Urology Group and it becomes necessary to take action to collect my account, I agree to pay all costs and expenses incurred in the collection of my account, including attorney and collection agency fees. I further agree to pay for any missed appointment of which I did not notify the medical office within 24 hours.

I authorize LMG, PC/The Urology Group to test my blood for hepatitis and/or AIDS virus, if in their opinion, an employee has suffered exposure incident as a result of my treatment, as defined by the Occupational Safety and Health Administration. I also authorize the healthcare staff to perform the necessary health care services that I (my child) may need.

Signature _____ Date _____