



# Foothills Urology, P.C.

## Insurance Information

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|--|--|
| Primary Insurance Carrier  | Secondary Insurance Carrier  |
| Claims Address   | Claims Address   |
| City, State, Zip Code  | City, State, Zip Code  |
| Phone Number(s)  | Phone Number(s)  |
| ID#  | ID#  |
| Group Number and Name  | Group Number and Name  |
| Insured's Name   | Insured's Name   |
| Is this policy provided through the insured's place of employment?<br>Yes No | Is this policy provided through the insured's place of employment?<br>Yes No |
| If yes, name of Employer _____   | If yes, name of Employer _____   |
| Effective date of coverage   | Effective date of coverage   |

The insurance information furnished here represents a full disclosure of the insurance benefits to which I am entitled. I understand that failure to disclose precertification / second opinion requirements for any and all plans to which I subscribe, may cause me to incur full liability for professional charges, as a result of non-payment by any carrier.

### Assignment of Benefits

I hereby authorize and direct my insurance carrier(s), including Medicare, to issue payment directly to Foothills Urology, P.C., for medical services rendered to myself and/or my dependents regardless of my insurance benefits. I understand that I am responsible for any amount not covered by my insurance.

### Authorization to Release Information

I hereby authorize Foothills Urology, P.C., to furnish and/or release information necessary to insurance carriers concerning my illness and treatments, to process my insurance claim, and to allow a photocopy of my signature to be used to process my insurance claim. This order will remain in effect until revoked by me in writing.

### Financial Responsibility

All professional services rendered are charged to the patient and are due at the time of services, unless other arrangements have been made in advance. Necessary forms will be completed by our office staff to expedite insurance claims. However, depending on the type of insurance coverage, you are responsible for all fees incurred. I have requested medical services from Foothills Urology, P.C., on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized. A photocopy of this assignment is to be considered as valid as the original.

\_\_\_\_\_  
Responsible Party's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name