Please fill out and sign and return these forms to our office before your appointment. Return them to: customerservice@AtlantaVasectomyCenter.com

PATIENT INFORMATION SHEET

DATE _____

PLEASE PRINT CLEARLY

PATIENT NAME _____ DATE OF BIRTH_____AGE____SEX____

MARITAL STATUS _____ SOCIAL SECURITY NUMBER _____

ADDRESS _____

CITY _____ STATE _____ ZIP_____

HOME PHONE _____ CELL PHONE _____

EMAIL _____ REFERRING DOCTOR_____

EMPLOYER _____ PHONE _____

ADDRESS _____ CITY _____ STATE _____ ZIP_____

SPOUSE (OR PARENT OF MINORS) _____ DATE OF BIRTH _____

SOCIAL SECURITY NO _____SPOUSE'S EMPLOYER _____
PHONE _____

PERSON TO CONTACT IN CASE OF EMERGENCY _____ PHONE _____

Payment is expected at the time service is rendered if there is no insurance to file. We will file insurance for patients who have coverage. Patient will be responsible for any balance that insurance does not cover of it there is no insurance coverage. This is not a guarantee of payment but an estimate. Actual payment and patient responsibility is determined when the claim is processed.

I authorize Georgia Regional Urology, P.C. / David L. Perlow, M.D. / Steven L. Perlow M.D. / Perlow Facility, LLC to release any and all information regarding diagnosis, treatment, and prognosis with respect to any physical condition and / or treatment of me to my insurance or its legal representative. Any such disclosure shall be limited to information that is reasonable and necessary for the discharge of the legal or contractual obligations of the insurance company. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim.

I understand that the information obtained by use of this authorization will be used by my insurance company to determine eligibility for benefits under an existing policy. Any information obtained may only be released by my insurance company to any other person or organization as governed by HIPPA or unless I so authorize. I also authorize payment of all medical benefits to be made payable to David L. Perlow, M.D. / Steven L. Perlow, M.D. / Georgia Regional Urology, P.C./Perlow Facility, LLC. I give my permission to be examined and treated by David L. Perlow, M.D./ Steven L. Perlow, M.D. I agree to all of the above.

X _____ _____

Signature of Patient or Parent of Minor Date

I understand that on occasions neither of our physicians may be available on call. In those situations, an alternative urologist may be taking calls. It is possible, that on some occasions neither Dr. Perlow nor a covering physician may be taking calls. In such cases, I understand that I may be directed to an ER where there is an urologist on call.

I have received a copy of Georgia Regional Urology, P.C.'s /Perlow Facility, LLC Notice of Privacy Practices and Ownership of Practice and Expertise of Physician, Patients' rights and Responsibilities, DNR Policy, Information Regarding the Grievance Procedure and Information Regarding Our Billing Practice. I have no language, visual or hearing problems which may affect my ability to communicate with the doctor. I understand that Georgia Regional, P.C. / Perlow Facility, LLC. May communicate with me via, fax, text, voice message or email and that those communications may not be securely encrypted.

X_____ _____

Signature of Patient or Guardian (**REQUIRED SIGNATURE)** Date

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IF YOU WISH FOR OUR OFFICE TO DISCLOSE HEALTH INFORMATION TO A FAMILY MEMBER PLEASE INDICATE BELOW:

PERMISSION TO DISCLOSE INFORMATION TO THE FOLLOWING:

NAME_____

ADDRESS_____ PHONE_____

SPECIFIC INFORMATION TO BE DISCLOSED:

[ ] ALL RECORDS [ ] OTHER EXPLAIN: _____

I agree to the above.

SIGNATURE OF PATIENT: _____

FILL THIS PORTION ONLY IF THIS IS A WORKMAN'S COMP CLAIM

Insurance Carrier Name _____ Phone_____

Employer at the time of injury _____ Phone_____

Date of Injury _____ Reported to _____

Claim Number _____ Case Manager _____ Phone _____