Tuscarawas Valley Urology, LTD

Michael R. Gigax, M.D.
Tina Alsept C.N.P.
300 Medical Park Drive – Suite 103
Dover, Ohio 44622
(330) 364-2311

As a courtesy to our other patients, please contact our office within 48 hours if you are unable to keep your appointment.
There is a $45.00 fee for any appointment not cancelled within 48hours.
Three consecutive missed appointments without proper cancellation will result in termination from our practice.

PATIENT INFORMATION

Patient Name: _____
First Name Middle Initial Last Name

Date of Birth: _____ Age: _____ Marital Status: _____

Social Security #: _____ Sex: Male / Female

Mailing Address: _____

Street Address: _____

Home Phone #: _____ Cell #_____

Email Address: _____

Is it okay to leave a message at your home? Yes / No

Employment Status: _____ Student Status: _____

Employer Name: _____

Employer Address: _____

Employer Phone #: _____

Is it okay to leave a message at your work? Yes / No

EMERGENCY CONTACT

Name: _____
First Name Last Name

Address: _____

Home Phone #: _____ Work Phone: _____

Cell #: _____

Relationship to patient: _____

***PRIMARY CARE PHYSICIAN:* _____**

***PHARMACY:* _____ PHARMACY PHONE: _____**

GUARANTOR

(Responsible Party if not patient)

Guarantor Name: _____

First Name Middle Initial Last Name

Address: _____

Home Phone #: _____**Social Security #:** _____

Sex: Male / Female Date of Birth: _____ **Relationship to patient:** _____

Employer Name: _____

Employer Address: _____

Employer Phone #: _____

Is it okay to leave a message at your work? Yes / No

INSURANCE INFORMATION

Primary Insurance Name: _____

Address: _____

Insurance Phone #: _____

Subscriber Number: _____

Group #: _____**Group Name:** _____

Insurance Co-payment: $_____

Subscriber Name: _____**Subscriber DOB:** _____

Relationship to patient: _____

Subscriber social security #: _____

Subscriber address: _____

Subscriber Phone #: _____

Subscriber Employer: _____**Employer Phone #:** _____

Employer Address: _____

_____

Secondary Insurance Name: _____

Address: _____

Insurance Phone #: _____

Subscriber Number: _____

Group #: _____**Group Name:** _____

Insurance Co-payment: $ _____

Subscriber Name: _____**Subscriber DOB:** _____

Relationship to patient: _____

Subscriber social security #: _____

Subscriber address: _____

Subscriber Phone #: _____

Subscriber Employer: _____**Employer Phone #:** _____

Employer Address: _____

Financial Policy

Tuscarawas Valley Urology, LTD. is pleased to provide your Urologic health care needs. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy, which you need to read and sign.

All patients or their legal representative shall complete an Information and Insurance form before seeing the doctor.

- Full payment is due at the time of service.
- Copayments are due at the time of service.
- Known coinsurance amounts are due at the time of service.
- We accept cash, checks, and credit cards. Returned checks will be subject to a $35.00 fee.
- Auto accident claims are your responsibility.
- This office is not a Bureau of Worker's Compensation Provider and will not coordinate any BWC claim.

REGARDING INSURANCE:

Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. The only exception: should the doctor have an agreement with your insurance company, we shall bill the company first **IF** it is a covered service by your insurance company. The doctor has some agreements with certain insurance companies in which the insurance company will be billed prior to the patient, however, the patient is responsible for deductibles, coinsurance and copayments at the time of service.

Not all services are a covered benefit. Some insurance companies have certain services they will not cover. You need to check with your insurance company regarding what services they will or will not cover. Check with your insurance company prior to your visit whether routine annual physicals or immunizations are covered. If not covered you are responsible for payment at the time of service.

USUAL AND CUSTOMARY RATES:

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

MINOR PATIENTS:

The adult accompanying a minor is responsible for full payment at the time of service.

MISSED APPOINTMENTS:

As a courtesy to our other patients, please contact our office within 48 hours if you are unable to keep your appointment.
There is a $45.00 fee for any appointment not cancelled with 48 hours.
Three consecutive missed appointments without proper cancellation will result in termination from our practice.

We understand that temporary financial problems may arise and affect timely payment on your account. Please contact our office promptly for assistance in the management of your account.

X_____ _____ _____
Signature of Adult Patient / Parent or Guardian Relationship Date

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Consent to Release all Medical Records for Insurance or Third Party Reimbursement

I, the patient or the patient's legal representative, hereby authorize and give my consent to Tuscarawas Valley Urology, LTD. and this office's agents to release all records prepared in the course of my treatment to any entity which provides financial assistance for the patient's healthcare including, but not limited to, insurance companies, self insured employers or public welfare agencies, and/or to maintain continuity of care.

I, the patient or the patient's legal representative, hereby authorize and give my consent to Tuscarawas Valley Urology, LTD. and this office's agents to release all records prepared in the course of my treatment to any entity, including but not limited to, referring physicians, hospitals, or other health care providers, which may be of assistance in the opinion of this office, in providing for the treatment of the patient.

I , the patient or the patient's legal representative, understand that by signing this form, records of a confidential nature, such as those for HIV testing, AIDS or AIDS related condition, psychiatric problems or substance abuse, will be released to the entities providing financial assistance for my health care.

I, the patient or the patient's legal representative, authorize that payment of any third party or insurance company benefits be made to this office for any services furnished to patient. The signature furnished below shall suffice for all insurance forms on a continuing basis.

X_____ _____ _____
Adult Patient / Parent or Guardian Relationship Date

NAME_____ **Date of Birth**_____

Tuscarawas Valley Urology, Ltd.
300 Medical Park Drive, Suite 103
Dover, Ohio 44622
(330) 364-2311
Fax (330) 364-7802

Permission To Release Medical Information To Family Member(s) / DPOA

I voluntarily give my permission to Tuscarawas Valley Urology, Ltd. to release any medical information to the following individuals as designated.

_____ DOB _____
(Printed) Patient's Name

X_____ _____
Patient's Signature Date

Names Designated	Relationship to Patient	Phone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____