St Luke's
Mountain States
Urology

Patient Information

Date _____

Name: Last _____ First _____ MI _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Date of Birth ____/____/_____ Gender _____ Social Security # ____/____/_____

Employer _____ Occupation _____

Referring physician _____

Responsible Party and/or Spouse Information ***(If different than above)***

Name: Last _____ First _____ MI ____ Relationship:_____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Date of Birth ____/____/_____ Social Security # ____/____/_____ Employer _____

Emergency Contact Information

Name _____ Phone Number _____

Insurance Information

Please bring insurance cards to your appointment.
If condition is related to an injury please see the receptionist.

Primary Insurance: _____

Policyholder's Name_____ Subscriber/Group # _____

Claims Address _____

City _____ State _____ Zip _____

Secondary Insurance: _____

Policyholder's Name_____ Subscriber/Group # _____

Claims Address _____

City _____ State _____ Zip _____

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OUTPATIENT SERVICES CONSENT

OUTPATIENT SERVICES CONSENT: I voluntarily consent to care by the physicians and staff of St. Luke's Mountain States Urology. Such care includes, but is not limited to, routine x-rays, laboratory and other diagnostic procedures, medical treatment and other medical services as necessary in the treating physician's judgment and normally provided by St. Luke's. This may include the taking of photographs and video that may be useful in treating or diagnosing my condition or that may be useful for medical education purposes or for making photographic record for my condition. I am aware the practice of medicine is not an exact science and I understand no guarantees have been made to me regarding the results of treatments or examinations. As a patient of St. Luke's Mountain States Urology, I understand that individuals being trained in health care may participate in my care. I consent to their presence and assistance under general supervision according to St. Luke's policy.

PERSONAL PROPERTY: I understand St. Luke's Mountain States Urology is not responsible for loss or damage to my personal property brought to St. Luke's Mountain States Urology.

FINANCIAL CONSENT: I agree to be responsible for payment of all St. Luke's Mountain States Urology charges. I also agree to be responsible for all professional fees covered by insurance or not. I will submit application to federal, state and county programs, when appropriate. I understand St. Luke's Mountain States Urology will bill me, my family and/or other responsible parties for services provided.

ASSIGNMENT OF INSURANCE PAYMENT: I voluntarily assign to St. Luke's Mountain States Urology the right to pursue their claims for reimbursement. I understand claims may be made upon any health insurance policy or policies providing coverage for care and treatment and for physician services rendered.

PATIENT'S RIGHTS AND RESPONSIBILITIES: My signature will confirm that I have been given the St. Luke's Patient's Rights brochure.

Patient's Signature	Date	Witness Signature	Date

The patient is unable to sign because: _____

Signature	Relationship to Patient	Date

NOTICE OF PRIVACY PRACTICES: I hereby acknowledge that I have received a copy of St. Luke's Notice of Privacy Practices on this day or on a previous visit to St. Luke's.

Patient Signature	Date

MEDICARE PATIENTS ONLY: I request that payment of authorized Medicare benefits be made either to me or on my behalf to St. Luke's Mountain States Urology for any services furnished to me by my provider. I authorize any holder of medical information about me to release to the Center for Medicare and Medicaid Service (formerly the Health Care Financing Administration) and its agents any information needed to determine these benefits payable for related services.

Patient Signature	Date