PIONEER VALLEY
UROLOGY, P.C.

*Expert, compassionate care of your genitourinary needs*

100 Wason Avenue, Suite 120
Springfield, MA 01107
Tel (413) 241-2100 Fax (413) 735-1986
www.pvurology.org

NAME: _____ SOCIAL SECURITY #: _____ - _____ - _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____

HOME #: (____) _____ WORK# (____) _____ CELL/OTHER# (____) _____

SEX: ☐ M ☐ F BIRTHDATE: _____ MARITAL STATUS: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

RACE: _____ ETHNICITY: _____ PRIMARY LANGUAGE SPOKEN: ☐ English ☐ Spanish ☐ Other _____

PLACE OF EMPLOYMENT: _____

PHONE: _____ BUSINESS ADDRESS: _____

PRIMARY CARE DR: _____ DR REFERRING YOU HERE _____

E-Mail Address: _____

**PRIMARY INSURANCE**

INSURANCE COMPANY: _____

I.D. #: _____ GROUP#: _____ SOCIAL SECURITY #: _____

SUBSCRIBER: _____ BIRTHDATE: _____ RELATIONSHIP: _____

SUBSCRIBER EMPLOYER: _____

**ADDITIONAL INSURANCE**

IS PATIENT COVERED BY ADDITIONAL INSURANCE? ☐ YES ☐ NO

INSURANCE COMPANY: _____

I.D. #: _____ GROUP#: _____ SOCIAL SECURITY #: _____

SUBSCRIBER: _____ BIRTHDATE: _____ RELATIONSHIP: _____

SUBSCRIBER EMPLOYER: _____

**DOES YOUR INSURANCE COMPANY REQUIRE THE FOLLOWING?**

A **REFERRAL** ☐ YES ☐ NO

DID YOU CONTACT YOUR PRIMARY PHYSICIAN FOR ONE? ☐ YES ☐ NO WHEN? _____

**EMERGENCY INFORMATION**

**Emergency Contact: _____ Relationship: _____ Phone#: _____

**Please make sure this person is listed on the HIPAA Omnibus Rule information sheet.

I, the undersigned, certify that I (or my dependent) have insurance coverage with the above insurance company(s) and assign directly to Pioneer Valley Urology, P.C., thereinafter known as P.V.U., all insurance benefits , if any, otherwise payable to me for services rendered. I understand that although P.V.U. will bill my insurance company directly, I will ultimately be financially responsible for all charges not covered by my insurance. If my insurance requires a referral to be seen at P.V.U. it is my responsibility to provide this office with the referral. If my insurance company denies payment due to no referral, I the patient, agree to pay P.V.U. in full for any charges incurred during my visit(s). I hereby give my consent to P.V.U. to use and disclose protected health information about me to carry out treatment, payment and healthcare options. I further certify that I have been given a copy of the HIPAA Privacy Practices for P.V.U..

I, the undersigned, give consent for evaluation and treatment, as deemed medically appropriate, at P.V.U.. I acknowledge that no procedure will be performed without my having been provided appropriate information regarding treatment and possible side effects or consequences.

_____ _____ _____

Patient, Parent or Legal Guardian | Relationship | Date