Avi T. Deshmukh, M.D., F.A.C.S., MBA, MHSM
Surgery, Diplomat of American Board of Urology

NORTH CENTRAL TEXAS UROLOGY
Treating the Whole Family

DATE:	Reason for APPT:		
PATIENT NAME	Last:	First:	MI:
Address:			Apt.#
City:		State:	Zip:
Date of Birth: ___/____/_____	Sex: M____ F____	Transgender____	SS# _____-_____-_____
Home Phone:	Cell Phone:	Work Phone:	
Email Address:			
Preferred contact method:		May we leave a Message? Y	N

Primary Care Physician:			Phone:
Primary Care Physician Address:			Fax:
Referring Physician Name:			Phone:
Referring Physician Address			Fax:

If you were not referred by a physician, how did you hear about our office? (circle one)

Newspaper Magazine Phonebook Internet Family/Friend Hospital/ER Former Patient

Employer Name:		Phone:	
Responsible Party: (if patient is minor)		Relationship:	
Address (if different from above)			
Emergency Contact Name:		Phone:	Relationship:
Pharmacy:	Address:	Phone:	Fax:

Optional

Ethnicity: (circle) Hispanic or Latino, Not-Hispanic or Latino

Race: (circle) American Indian or Alaska Native, Asian, Black or African American, Native Hawaiian or other Pacific Islander, White

Primary Insurance		Policy No.	Group No.
Policy Holder Name		DOB	Relationship to Patient
Secondary Insurance		Policy No.	Group No.
Policy Holder Name		DOB	Relationship to Patient

Patient/Legal Guardian Signature Date:

ASSIGNMENT OF BENEFITS / RELEASE OF INFORMATION / NOTICE OF PRIVACY PRACTICES
APPTOINTMENT OF AUTHORIZED REPRESENTATIVE

NORTH CENTRAL TEXAS UROLOGY Dr. Avi T. Deshmukh, M.D., FACS, MBA, MHSM

CONSENT TO TREATMENT: I, the undersigned, as the patient or on behalf of the patient, consent to authorize all diagnostic and therapeutic treatments considered necessary or advised by the practitioner. I understand that no guarantee or assurance has been made as to the results that may be obtained.

ASSIGNMENT OF BENEFITS: I request that payment of authorized Medicare and other insurance benefits be made on my behalf to North Central Texas Urology, PLLC for any services furnished to be by any healthcare providers associated with that group.

ACCESS TO MEDICAL INFORMAITON: I give consent to release, permit access to, or inspection of my medical information to my insurance company, State and Federal authorities and their representatives for any information needed to determine benefits payable for related services. I appoint North Central Texas Urology, PLLC to act as my authorized representative in requesting payment for services described.

MEDICARE/MEDICAID BENEFICIARIES: I certify that the information given in applying for payment is correct. I authorize release of all records required to act on this request for payment of authorized benefits be made to North Texas Urology, PLLC.

PATIENT FINANCIAL RESPONSIBILITY STATEMENT

We accept cash, check, debit/credit cards and Care Credit.

In order to maintain our fees at the lowest possible level, it is important that we have a good understanding with our patients regarding financial responsibility. We hope that this summary will be helpful toward that end. We encourage you to discuss it with us and to ask questions.

It is your responsibility to provide us with your most current insurance information.

- If you have out-of-network benefits, we will file claims on your behalf, however, you are responsible for services not considered a benefit by your insurance company.
- You must pay any co-payment and applicable deductible amounts at the time of service unless other arrangements have been made with our office.
- The remainder of your bill will be sent to your health plan for direct payment to our office.
- If your insurance carrier has not paid our claim within 45 days, we will expect payment from you.
- If, by mistake, your health plan remits payment to you, please send it to us along with all paperwork sent to you at the time. You will remain responsible for amounts and any services that are not covered by your insurance plan.
- If you do not have insurance, a 20% discount for professional services is given if your balance is paid in full on the day of service.
- In the event you submit payment by check and the bank returns the check unpaid, we will add $30.00 to your original balance. In addition, we may seek all legal remedies provided to us under Texas law for account collection.
- **Failure to keep your account balance current may require us to cancel or reschedule your appointment.**

Please understand that the financial responsibility for medical services rests between you and your health plan. While we are pleased to be of service by filing your medical insurance for you, we are not responsible for any limitations in coverage that may be included in your plan. If your health plan denies this claim for any of these or other reasons, our office cannot be responsible for this bill. It is your responsibility as the patient to pay the denied amounts in full.

Our primary mission is to provide you with quality, cost effective, medical care. Together we are trying to adapt to the changing way that health care is financed and delivered. Again, we value you as a patient and our first priority is to provide you with the best possible care. With this housekeeping core complete, we are pleased to serve you.

I have read and understand the authorizations, consents and agreements above and accept the terms as described. I acknowledge that I am fully responsible for supplying correct insurance information, billing information, and payment of any services not covered or approved by my insurance carrier. I understand that full payment is due at time of service.

_____ _____

SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE DATE

_____ _____

PATIENT NAME PATIENT DATE OF BIRTH