Patient Name:

_____

DOB:

_____/_____/_____

# Insured's Information

Gillespie County UROLOGY

**Circle One: Mr. Mrs. Miss Ms. Dr.**

**Last Name:_____First:_____MI_____**

**Address:_____**

**City:_____State:_____Zip:_____**

**Home Phone: (_____)_____Cell (_____)_____SSN:_____**

**Date of Birth:_____ Sex: Male Female**

**What is the relationship of the patient to the insured? Self Spouse Child Other**

**PRIMARY INSURANCE:_____**

**Insurance Address:_____**

**Insurance Phone#:_____GRP#_____Policy#_____**

**SECONDARY INSURANCE:_____**

**Insurance Address:_____GRP#_____Policy#_____**

**Insurance Phone#:_____**

**AUTHORIZATION TO RELEASE INFORMATION, ASSIGNMENT OF INSURANCE BENEFITS AGREEMENT/CONTRACT**

I hereby authorize Michael C. Speck M.D., P.A. to release to my primary and secondary insurance company any medical information necessary to process my insurance claim. My signature also authorizes any insurance benefits to be paid on my behalf to the provider Michael C. Speck M.D., P.A. I hereby agree to full responsibility for all expenses incurred by myself or minor child. I understand that a re-billing fee/finance charge complying with Texas State Law will be applied to any overdue balance. In the event of non-payment, I will bear the cost of collection and/or court costs and reasonable legal fees should this be required. **Medicare: I understand that my provider is contracted with Medicare and I agree to pay the physician for services Medicare may determine to be "non-covered" or "medically unnecessary". I understand that my provider will obtain my authorization prior to performing services which have limited coverage under Medicare rule.

**Medicare Lifetime Signature on File:** I request that payment of authorized Medicare benefits be made on my behalf to Michael C. Speck, M.D., P.A. for any services furnished to me by the physician. I authorize any holder of medical information about me be released to Medicare and their agents.

**Consent for Treatment:** I consent to the use or disclosure of my protected health information by Michael C. Speck, M.D., P.A. for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Michael C. Speck, M.D., P.A. I understand that diagnosis or treatment of me by any physician, provider or staff member employed by or under contract to Michael C. Speck, M.D., P.A. may be conditioned upon my consent as evidenced by my signature on this document. I have the right to revoke this consent, in writing, at any time, except to the extent that any physician, provider or staff member employed by or under contract to Michael C. Speck, M.D., P.A. has taken action in the reliance on this consent.

**Patient Name:_____**
**(Parent/Guardian if Patient Is a minor)**

**Patient Signature:_____Date:_____**
**Entered By:_____**