NEW PATIENT PAPERWORK

1892 W US HWY 290
FREDERICKSBURG, TX 78624
(P) 830-304-1666 (F) 830-304-1665
www.gillespiecountyurology.com

NAME: FIRST_____MI_____LAST_____

DATE OF BIRTH_____/_____/_____ AGE_____ SS# _____-_____-_____

MAILING ADDRESS_____

CITY_____ STATE_____ ZIP_____

BY PROVIDING YOUR NUMBER YOU ARE CONSENTING TO CALLS/TEXTS FROM OUR CLINIC

CHECK **HOME** OR **CELL** AS YOUR **PRIMARY** PHONE NUMBER

☐ HOME _____ ☐ CELL_____

BY PROVIDING YOUR EMAIL ADDRESS YOU ARE CONSENTING TO CREATION OF A GILLESPIE COUNTY UROLOGY PATIENT PORTAL ACCOUNT

EMAIL_____

PRIMARY CARE DOCTOR_____REFERRED BY_____

PRIMARY PHARMACY_____

INSURANCE INFORMATION - MUST PROVIDE CARDS TO OFFICE

PRIMARY INSURANCE_____

ID#_____GROUP#_____

MEMBER NAME_____DOB_____

SECONDARY INSURANCE_____

ID#_____GROUP#_____

MEMBER NAME_____DOB_____

AUTHORIZATION TO RELEASE INFORMATION, ASSIGNMENT OF INSURANCE BENEFITS AGREEMENT/CONTRACTI 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 my provider will obtain my authorization prior to performing services which have limited coverage under Medicare rule. **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/Guardian if Minor_____

Patient Signature_____Date_____