WASHINGTON HEIGHTS UROLOGY, PC

286 Ft. Washington Avenue
New York, NY 10032
212-781-9696

Date: _____ **SSN: _____**

Last Name: _____ **First Name: _____**

Date of Birth: _____ **Telephone #: _____**

Address: _____ **Apt.: _____**

State: _____ **Zip Code: _____**

Email Address_____

Status: _____ **Race: _____**

Primary Care Physician: _____

Ethnicity: _____ **Preferred language: _____**

Preferred Pharmacy: _____

ASSIGNMENT OF BENEFITS

In consideration of services rendered, I herby assign to the provider and/or his assignee benefits to be paid on my behalf to the provider. I understand that I am financially responsible for any Balance not covered by my insurance carrier; for any charges not paid by my insurance company due to incorrect information provided by me. I will also be responsible for charges not paid by insurance for missing Referral. I also understand that I will be held financially responsible and agree to pay attorneys and processing fees that might be incurred to collect payment in full. I authorize release of medical information to my insurance when needed to determine benefits payable.

_____ _____ _____

Patient's Signature Date Parent's Signature (if patient a minor)

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- ***Office Policy: 24 hours cancelation notice is required to avoid $25.00 dollars No Show Fee***