UROLOGY GROUP OF SOUTHERN CALIFORNIA

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INSURANCE INFORMATION FORM – INFORMACION DE ASEGUARANZA

Name of Insured – *Nombre del Asegurado:*______________________________

Address – *Domicilio del Asegurado:*______________________________

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Home Phone – *Telefono:*__________________ *Email:*__________________

Date of Birth – *Fecha de Nacimiento:* __________________ SS#: __________________

Driver's License – *Numero de Licensie:*______________________________

Relationship to Patient – *Relacion del Paciente:*______________________________

PRIMARY· *PRIMERA*

Insurance Company – *Compania de la Aseguranza Medica:* ______________________________

Insurance Plan & Group # – *Nombre del Plan y Groupo:* ______________________________

Member ID# – *Numero de la Aseguranza Medica:*______________________________

SECONDARY – SEGUNDA

Insurance Company – *Compania de la Aseguranza Medica:* ______________________________

Insurance Plan & Group # – *Nombre del Plan y Groupo:* ______________________________

Member ID# – *Numero de la Aseguranza Medica:*______________________________

AUTHORIZATION & ASSIGNMENT· *AUTHORIZACION Y AS/GNAMIENTO DE BENEFICIOS*

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Initial – *Inicial*

AUTHORIZATION FOR TREATMENT, RELEASE OF INFORMATION, AND ASSIGNMENT OF BENEFITS. I authorize the Urology Group of Southern California to provide medical care and treatment. I authorize the Urology Group of Southern California to release medical information to my insurance company(s) necessary for the payment of benefits. I authorize my insurance company(s) to pay benefits directly to the Urology Group of Southern California.
Autorizo al Urology Group of *Southern California* a *proveer cuidado* y *tratamientos medicos. Autorizo al Urology Group* of *Southern California* a *dar la informacion medica que* es *necesaria para el pago de beneficios* a *mi compeiile de aseguranza. Autorizo el pago de los beneficios de seguro para ser hecho directamente al Urology Group* of *Southern California.*

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Initial – *Inicial*

FINANCIAL RESPONSIBILITY. I understand that I am financially responsible for the cost of all medical services. However, The Urology Group of Southern California will bill my insurance company as a curtesy to me.
Yo entiendo que soy *responsable financieramente por todos los cargos. Como quiera, Urology Group of Southern California Ie cobrara* a *mi compania de aseguranza* como *una cortesia*

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Initial – *Inicial*

LATE FEES. Invoices sent to me by Urology Group of Southern California are due within 25 days after the date of invoice. I may be charged a 1.5% per month late fee on the unpaid balances. Failure to keep my account current may result in my being denied additional services except in emergencies or if I prepay for additional services. I agree to pay collection costs and reasonable attomey fees incurred in collecting outstanding account balances.
Las facturas enviadas a *mi por Urology Group of Southern California tendran que ser pagados entre* 25 *dias despues de la feche de la factura. Yo podre* ser *cobrado e11.* 5% *porciento por* mes *de cargos sin pagar del balance.* De *cargos sin pagar del balance resultaran en ser negado servicios adicionales excepto en emergencias* o *si pago por adelantado por servicios neuvos. Yo* estoy *deacuerdo con* costos *de colecsion* y costos de *abogado rasonables que Urology Group of Southern California ah inquerido en colectar balances no pagados.*

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Initial – *Inicial*

MISSING AN APPOINTMENT. I understand that when I make an appointment, my doctor and his staff will block out time in their schedule to see me. I can cancel my appointment or reschedule it up to 24 hours in advance with no penalty. However, if I do not cancel or reschedule my appointment at least 24 hours in advance and I fail to show up at the appointed time, I agree to pay a $25.00 fee for the doctor's time and will be personally liable for the payment in accordance with California State and Federal law unless my medical plan specifically exempts me from such payments.
Yo entiendo que cuando hago una cita, mi doctor y sus *trabajadores reserbaran tiempo en* su *agenda para mi. Yo puedo cancelar mi cita* o *cambiar mi cita antes de* 24 horas *en avansado sin ser penado. Si yo no cance/o mi cita* o *cambio mi cita antes de* 24 *horas en avansado* y *si no I/ego* a *mi cita, yo pagare una multa de $25.00 por el tiempo del doctor amenos que mi aseguranza proiva* estos cargos.

Signature' *Firma del Asegurado:* ______________________________ *Date – Fecha:* __________