

ALABAMA UROLOGY ASSOCIATES, P.C.
BROOKWOOD MEDICAL CENTER

W. Glen Wells, M.D., FACS

Paula J. Rookis, M.D.

(Please Print)

PATIENT'S NAME _____ Date _____
(Last) (First) (Middle Initial) AGE _____
Address _____
(Street) (City) (State) (Zip)
Social Security # _____ Home Phone # _____ Work Phone # _____
Date of Birth _____ Sex _____ Marital Status _____ Cell Phone # _____
Employer _____ Referred By _____
Occupation _____ Spouse's Name _____
Spouse's Date of Birth _____
Pharmacy Name _____ Spouse's Social Security Number _____
Pharmacy Number _____

PERSON TO CONTACT IN CASE OF EMERGENCY (Not Living with Parents)

Name _____ Relation to Patient _____ Telephone # _____

RESPONSIBLE PARTY

Name _____ Relation to Patient _____
Address _____
Phone # _____ Social Security # _____

INSURANCE INFORMATION

Primary: _____ Contract # _____ Policyholder _____
Group # _____ Policyholder Date of Birth _____
Secondary : _____ Contract # _____ Policyholder _____
Group # _____ Policyholder Date of Birth _____

Copay: \$ _____

Note: As a patient of Alabama Urology, I understand that I may be required to have any or all of the following tests prior to hospitalization or surgery:
(CBC) Complete, Blood Count, (U/A) Urinalysis, and (HTLV-3) Aids Testing.

I consent to treatment necessary for the care of the above named patient.

I authorize the physicians of Alabama Urology Associates, P.C., to release my records to my insurance company when requested. Records may be requested to verify medical benefits or to authorize payments for services rendered. I allow fax transmittal of my medical records, if necessary.

I understand that I am responsible for my entire bill, and the cost of my medical care may exceed the amount(s) reimbursed by my insurance companies. I agree I am responsible for any services not covered by my insurance company including co-pays, deductibles, etc, and agree to pay any and all cost necessary for bill collection, including a reasonable attorney's fee.

I have read and fully understand the above consent for treatment, release of medical information, insurance authorization, and financial responsibility.

Patient (or Responsible Party) _____ Date _____

I acknowledge I have read and completely understand Alabama Urology Associates' notice of privacy practices.

Patient (or Responsible Party) _____ Date _____

Alabama Urology Associates is affiliated with Alabama Research Center and we participate in clinical research trials. I authorize Dr. Glen Wells or Dr. Paula Rookis or the research coordinator to review my medical record for potential clinical trials that may be beneficial to me.

Patient (or Responsible Party) _____ Date _____