LAS VEGAS UROLOGY

Annual Patient Update Form

Patient Name: _____ Date: _____

Demographic Information **____No changes to demographic information**

Email: _____
Address:_____
Cell Phone:_____ Home Phone:_____ Work Phone:_____
Primary Care Physician:_____

Insurance Information **____ No changes to insurance information**

Primary Insurance:	**Secondary Insurance:**
Name of Insurance:_____	Name of Insurance:_____
Policy Num:_____	Policy Num:_____
Group Num:_____	Group Num:_____
Subscriber Name:_____	Subscriber Name:_____
Subscriber's Date of Birth: _____	Subscriber's Date of Birth: _____
Relationship to Subscriber:_____	Relationship to Subscriber:_____

Pharmacy Information **____No changes to pharmacy information**

In the event we need to send a prescription to your pharmacy electronically, please provide your updated pharmacy information.
Pharmacy Name: _____ Cross
Streets:_____
Phone Number:_____

Medical History

Height_____ Weight:_____

____ No other changes to medical history

Allergies:_____
Medications: _____
New medical conditions or symptoms: _____
_____
Surgery: _____
Hospitalization: _____

_____ _____

Patient Signature Date

Notice of Financial Responsibility for Telehealth Services

Dear Patient,

At Las Vegas Urology, we are pleased to offer telehealth services for non-emergent/urgent health concerns. Please carefully review the following information regarding your financial responsibilities for telehealth services:

1. **Insurance Coverage**
    - Telehealth services may or may not be covered by your health insurance provider.
    - It is your responsibility to confirm coverage with your insurer prior to your telehealth appointment.
2. **Out-of-Pocket Costs**
    - If your insurance covers telehealth services, you may still be responsible for co-pays, deductibles, or other out-of-pocket expenses as determined by your insurance policy.
    - If telehealth services are not covered by your insurance or you do not have insurance, you will be charged a **cash pay rate of $100** per telehealth visit.
3. **Billing and Payment**
    - Las Vegas Urology will contact you before your telehealth visit to collect any estimated responsibility, such as co-pays, deductibles, or co-insurance, as outlined by your insurance policy.
    - Any additional balance due after insurance processing will be your responsibility.

By signing below, you acknowledge and agree to the following:

- You have read and understand the financial policies outlined above.
- You accept financial responsibility for any fees associated with telehealth services, including charges not covered by your insurance.

Date: _____

Patient Name: _____

Patient Signature: _____

Thank you for choosing Las Vegas Urology for your care. If you have any questions or concerns regarding this policy, please feel free to contact us.