DEPARTMENT OF UROLOGY ASSOCIATES

Patient Registration Form

Name/Nombre: _____

Address/Direcion: _____

Telephone/Telefono: (HM) _____ (Cell) _____ (Preferred) _____

Date of Birth/Fecha De Nacimiento: _____Soc.Sec. #:_____Male:____ Female:_____

Marital Status: Single___ Married___ Divorced___ Widowed___ Preferred Language:_____

Emergency Contact:_____Telephone#_____Relationship:_____

Referring Physician Name:_____Telephone#_____

Employer:_____Address:_____Telephone#_____

Pharmacy Name/Address/Phone#:_____

BILLING INFORMATION

Patient Relationship to Insured: ____ Self ____ Spouse ____Child ____ Parent ____Other Self Pay: ____

Primary INS: _____ID#_____Secondary INS:_____ID#_____

RELEASE OF INFORMATION: I authorize this office furnish my insurance carriers with any information relevant to my claim, and for the insurance carrier to make direct payment when accepted.

Signed:_____ Date:_____

MEDICARE AUTHORIZATION: I authorize any holder of medical or other information about me to be released to Social Security Administrations or their intermediaries or carriers, or to the billing agent of this physician, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of the medical insurance benefits to either myself or to the party who accepts assignment.

Signed:_____ Date:_____

ASIGNMENT OF BENEFITS

I understand that I am financially responsible to the **Department of Urology Associates** for any charges not covered by my health care benefits. It is my responsibility to notify the organization of any changes in my health care coverage. In some cases exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by the Department of Urology and /or my healthcare insurer if the submitted claims or any part of them are denied for payment. I understand that by signing this form, I am accepting financial responsibility as explained above for all payment for products received.

In Certain Circumstances, an insurance company may send for services provided by the Department of Urology directly to the patient. In some cases, the patient agrees to endorse and send such check to the Department of Urology. If the patient deposits such check into a personal account, the patient agrees to send the Department of Urology a check for the equivalent amount. If the patient receives an Explanation of Benefits (EOB) from an insurance company, the patient agrees to send a copy of the EOB directly to us.

_____ _____

Signature of Insured or Parent/Guardian Date