Registration Form

THE UROLOGY GROUP
Advanced Care. Improving Lives.

Patient Name: _____ Age _____ Date of Birth _____
LAST FIRST MI

Please circle: Male / Female Marital Status: Single Married Divorced Surviving Spouse

Address: _____ ☐ Home Phone: _____

City / State / Zip: _____ ☐ Work Phone: _____

Social Security #: _____ ☐ Cell Phone: _____
(Mark primary number.)

Email: _____

Employer: _____ Occupation / Dept.: _____

Employer Address: _____

Are you in Hospice? _____ Name of Facility: _____

Do you live in a Nursing Home? _____ Address of Facility: _____

Emergency Contact: _____ DOB: _____ Relationship: _____

Home Phone: _____ Work Phone: _____ Cell: _____

Spouse Name: _____ Date of Birth _____
LAST FIRST MI

Social Security #: _____ Employer: _____ Occupation: _____

Address: _____

Person Responsible for Charges? _____
(If patient has a legal Guardian) Name Home Phone Work Phone

Family Physician: _____ Reason for Appointment: _____

Referring Physician: _____ Address: _____

Drug Allergies: _____ Latex Allergy? _____

Pharmacy: _____ Phone: _____

Primary Insurance: _____ Policy #: _____ Group #: _____

Address: _____

Subscriber's Name: _____ Subscriber's Date of Birth: _____

Secondary Insurance: _____ Policy #: _____ Group #: _____

Address: _____

Subscriber's Name: _____ Subscriber's Date of Birth: _____

Today's Date: _____

Providing quality medical care for our patients is our primary concern. We are more than willing to provide that care within your insurance contract guidelines if you let us know at each time of service exactly what those guidelines are. Unfortunately, if you do not inform us of any special requirement in your contract and we subsequently order services, such as lab work, x-rays, or hospitalization, that are not covered, we or the selected medical facility will have no choice but to bill you directly for those charges. Payment for those charges is then your responsibility. As the policy holder, YOU ARE RESPONSIBLE for knowing the benefits and restrictions of your insurance coverage.

WAIVER: I understand that should my insurance company require a REFERRAL/AUTHORIZATION prior to my receiving Medical Service and I have not obtained this and/or this office has not received this, I WILL BE RESPONSIBLE FOR ALL CHARGES INCURRED.

I understand that should it become necessary to place my account with an outside collection agency there will be an **additional 30% late fee** added to my delinquent balance.

I HAVE READ AND UNDERSTAND THE OFFICE POLICY STATED ABOVE AND AGREE TO ACCEPT RESPONSIBILITY AS DESCRIBED.

Signature: _____ Date: _____

*A $35.00 charge will be collected for all RETURNED CHECKS.
**A $35.00 charge will be collected for all DECLINED CREDIT CARDS.

Medicare Lifetime Signature on File

_____
Name of Beneficiary

_____
HIC Number

I request that payment of authorized Medicare benefits be made either to me or on my behalf to TRI STATE UROLOGIC SERVICES, P.S.C., INC. for any services furnished me by TRI STATE UROLOGIC SERVICES, P.S.C., INC. or their contracted agents PeriOp Anesthesia, P.S.C. or Professional Radiology Inc. or Southern Ohio Pathology. I authorize any holder of medical information about me to release the Center for Medicare/Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If item 9 of the HCFA-1500 claim form is completed, my signature authorizes releasing of the information to the insurer or agency shown. In Medical assigned cases, the physician agrees to accept the charge determination of the Medical carrier as the full charge and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier. In Medicare non-assigned cases, the patient is responsible for the entire charge.

Patient Signature: _____ Date: _____

_____
Witness if signed with an “X”