Patient Registration Form

THE UROLOGY GROUP
Advanced Care. Improving Lives.
25TH ANNIVERSARY

Today's date: _____

Patient name: _____ Age: ____ Date of birth: _____
LAST FIRST MI

Please circle: Sex: Male / Female
Marital status: Single / Married / Divorced / Widowed

Address: _____

City / State / ZIP: _____

Phone: (check primary number)
☐ Home: ( ) _____ SS#: _____
☐ Mobile: ( ) _____
☐ Work: ( ) _____ Email: _____ @ _____

Emergency contact: Name: _____ Relationship: _____
Home: ( ) _____ Mobile: ( ) _____

Spouse: Name: _____ Date of birth: _____
☐ Check if same as emergency contact Phone: ( ) _____

Nursing home/hospice: (Check if applicable)
☐ I live in a nursing home Facility name: _____
Address: _____
☐ I am in hospice care Facility name: _____

Family physician: _____ Phone: ( ) _____

Referring physician: (if other than above): _____ Phone: ( ) _____

Pharmacy name: _____ Phone: ( ) _____

Person responsible for charges: _____ Home: ( ) _____
LAST FIRST
☐ Check if same as patient Work: ( ) _____

Primary insurance: _____ Policy #: _____ Group #: _____
Subscriber's name: _____ Subscriber DOB: _____

Secondary insurance: _____ Policy #: _____ Group #: _____
Subscriber's name: Subscriber DOB:

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”