Greater AUSTIN Urology

REGISTRATION FORM (PLEASE PRINT)

Primary Care Physician/Referring Physician	Today's Date:

PATIENT INFORMATION

Patient's Last Name:	First:	Middle:	Age:	❑ Male ❑ Female	Date of Birth: / /
Street Address:		Social Security No.:			Best Contact Phone Number: ( )
City/State	ZIP Code:		Marital Status ❑ Married ❑ Divorced ❑ Single		Secondary Phone Number: ( )

Ethnicity:
❑ Hispanic or Latin
❑ Not Hispanic or Latin
❑ Refuse to Report

Race:
❑ American Indian or Alaska Native
❑ Asian
❑ Native Hawaiian
❑ Black or African American
❑ White
❑ Hispanic
❑ Other Race
❑ Other Pacific Islander

GUARDIAN INFORMATION: If different than patient

Primary Parent / Guardian Name:	Email: e:	
	Social Security No.:	Date of Birth:
Employer:	Employer phone No.: ( )	
Second Parent / Guardian Name:		

INSURANCE INFORMATION

Name of Primary Insurance:	Subscriber's Name:	Birth Date: / /	Subscriber's SSN:		Relationship to patient: ❑ Self ❑ Spouse ❑ Child ❑ Other
Policy No:			Group No:		
City:	State:		ZIP Code:		
Name of Secondary Insurance:	Subscriber's Name:	Birth Date: / /	Subscriber's SSN:		Relationship to patient: ❑ Self ❑ Spouse ❑ Child ❑ Other
Policy No.			Group No:		
City:	State:		ZIP Code:		

EMERGENCY CONTACT

Last Name:	First:	Middle:	Home Phone Number : ( ) Cell Phone Number: ( )	
Street Address:		Relationship to Patient:		Email:
City:	State:		ZIP Code:	

APPOINTMENT INFORMATION

Referred by (Full name):	Reason for today's visit:

My signature below affirms my patient registration information is complete and true.

Signed: _____ Relationship: _____ Date _____

Consent to Treat

I hereby consent to evaluation, diagnostic procedures, testing, and treatment as directed my physician or his/her designee.
I give my consent for the licensed health care professionals of Greater Austin Urology to examine my person, perform medical diagnostic studies and give medical treatment which is consistent with the standards of medical care. I understand that this **Consent to Treat** will be valid for each visit I make to the Greater Austin Urology until revoked by me in writing.

Recalls/Reminders/Verification of Benefits

Recalls/Reminders/Verification of Benefits are a courtesy and not guaranteed to be sent out or completed. It is the patient or patient guardian's responsibility to set up all follow up and yearly appointments, obtain referrals from insurances and know their benefits.

Contact/ Release of Information

In the event that Greater Austin Urology need to contact you regarding an appointment, lab result, medication or for any other reason, it is permissible to:

❑ Leave a message on an answering machine/ Voicemail
❑ *Other:
❑ *Speak with spouse/ significant other
❑ *Speak with other family member

**Name_____ **Relationship to Patient:_____

I acknowledge that Greater Austin Urology may release my protected health information as necessary for treatment, payment and health care operations and acknowledge that Greater Austin Urology' s Notice of Privacy Practice provides information on how my protected health information may be used and/or disclosed for these purposes. I understand that protected health information pertains to my diagnosis and/or treatment, and includes, but is not limited to, information related to my health history, diagnosis, treatment, prognosis, mental illness (excluding psychotherapy notes), use of alcohol or drugs, prescriptions and laboratory test results, including HIV or the diagnosis of AIDS.
I understand that use or disclosure of my protected health information may be necessary before my insurer will pay for the cost of my medical treatment and that if I refuse to consent to this disclosure I may be required to pay the entire cost of medical care provided by my provider.
I acknowledge and consent to allow Greater Austin Urology to use health information exchange systems to electronically transmit, receive and/or access my medical information, which may include, but is not limited to, treatments, prescriptions, labs, medical and prescription history and other protected health information. I may request not to have my protected health information disclosed through health information exchange systems by providing a **written and signed** request to the practice location where I receive treatment.

Financial Policy

I assign and transfer to Greater Austin Urology all rights, title and interest in payments from third-party payors, including but not limited to, health plans, health insurers, Personal Injury Protection (PIP)/Uninsured Motorist/Under Insured Motorist (UIM/UM), auto or homeowner's insurance. I understand that it is my responsibility to know my insurance benefits and whether or not the services I receive are a covered benefit. I understand and agree that I will be responsible for any deductible, co-pay or balance due that Greater Austin Urology are unable to collect from my third-party payor for whatever reason. If my account becomes delinquent and it is necessary for the account to be referred to attorneys' or collection agencies, or lawsuit filed, I agree to pay all patient charges, reasonable attorneys fees and collection expenses.
I authorize the release all medical information necessary to process all claims and the release of payment for medical benefits to my physician and Greater Austin Urology. I agree to pay any outstanding balance for services not covered by insurance, applicable copays, co-insurance, deductible, and replacement costs for items damaged.

My signature below affirms my patient registration information and acceptance of the financial terms, responsibilities and consents as stated herein.

Patients Name:_____Date of Birth:_____

Signature: _____Relationship: _____ Date _____

Insurance Card Policy

Please present your current ***Insurance Card*** and ***Photo ID*** at check-in. Both are required to process insurance claims. Your appointment will be rescheduled to our next available opening if you do not bring these documents or if you do not obtain a referral, if required by your insurance. You are responsible for obtaining a referral from your PCP if one is required.

Medicare/Medicaid/Insurance Benefits

If I am eligible for health care benefits under any federal or state program, including, but not limited to Medicare or Medicaid, I certify that the information given by me in applying for payment under any such programs is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or Contractors any information needed for any federal or state program related claims. I request that payment or authorized benefits be made to Greater Austin Urology on my behalf. I understand that I am financially responsible for any deductible, co-pay or balance due under these programs.

Acknowledgement of Receipt of the Notice of Privacy Practice

I acknowledge that I have reviewed a copy of Greater Austin Urology Notice of Privacy Practices. I understand how medical information will be used and disclosed. I understand a copy will be given to me upon request.

General Office Policies

- The practice does not accept "walk-in" patients or appointments, unless it is an emergency.
- Please arrive to the clinic at least 15 minutes prior to your scheduled appointment.
- If you are more than 30 minutes late, the physician reserves the right to reschedule your appointment. If you are late, and the physician agrees to see you, you will lose your appointment and be seen after those patients who arrive on time. This may result in a prolonged wait time.

No Show policy

Greater Austin Urology is committed to providing the highest quality care to our patients. Our staff will work hard to get you an appointment at a convenient time. No-shows, or missed appointments, have a great impact on our ability to provide timely access to care. When a person fails to show up for their scheduled appointment or fails to give us a 24 hour notice to either reschedule or cancel their appointment, it leaves an empty time in our physician's schedule that could have been used by a patient in need. **All scheduled appointments not cancelled 24 hours prior without a valid excuse are subject to a $40.00 fee.** If you miss or cancel more than 2 consecutive appointments we will be unable to schedule future appointments.

By signing below, you understand and agree to all policies.

_____ _____

Patient Printed Name Patient Date of Birth

_____ _____

Patient/Responsible Party Signature Date