ASSOCIATED UROLOGICAL SPECIALISTS

PATIENT REGISTRATION FORM

PATIENT INFORMATION			
Patient Last Name:	**First:**		**MI:**
DOB:	**Social Security #:**		
Referring Physician:	**Sex:** ☐ **M** ☐ **F**		
Address 1:			
Address 2:	**City:**	**State:**	**Zip:**
Home Phone:	**Work Phone:**		
Cellphone:	**Email:**		
Emergency Contact:			
Relationship to the Patient:	**Emergency Phone #:**		
The U.S. Department of Health & Human Services Centers Medicare & Medicaid Services has established a number of criteria physicians must obtain from their patients. Your answers below do not impact services you receive			
Patient Race:	**Preferred Language:**		
Patient Ethnicity:	**Preferred Method of Contact:**		

GUARANTOR INFORMATION			
Last Name:	**First:**		**MI:**
DOB:	**Social Security #:**		
Address 1:			
Address 2:	**City:**	**State:**	**Zip**
Home Phone:	**Work Phone:**		
Cell Phone:	**Email:**		
Employer:			
Employer Address:			
City:	**State:**	**Zip:**	

INSURANCE INFORMATION	
Primary Insurance:	**Secondary:**
Certificate #:	**Certificate #:**
Group #:	**Group #:**
Group Name:	**Group Name:**
Co-Pay:	**Co-Pay:**
Subscriber Name:	**Subscriber Name:**
Subscriber DOB:	**Subscriber DOB:**
Subscriber SSN:	**Subscriber SSN:**
Is this a result of an accident? ☐ **Yes** ☐ **No**	

ASSIGNMENT OF INSURANCE BENEFITS/PAYMENT GUARANTEE/COLLECTION FEE

I hereby authorize Associated Urological Specialists, LLC and its agents to release to and discuss with my insurance company, physician and/or employer, for work related injuries, and that payment of charges is not contingent upon settlement from my insurance carrier and that I am responsible for any unpaid balance. I also understand that if my account balance becomes overdue and the overdue account is referred to a collection agency, a collection fee, not to exceed 25% of the overdue balance, maybe added to the amount due and that I am financially responsible for the added collection fee and any reasonable attorney's fees and other costs incurred for collection. Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You may have the right to review our notice before signing this consent. By signing this form you consent to our use and disclose of protected health information about you for your treatment, payment and health care operations. You have the right to revoke this consent, in writing except where we have already made disclosures in reference to your prior consent.

_____ _____

Patient/Guardian Signature **Date**