Urology of Indiana

PATIENT REGISTRATION FORM

Please answer all questions to the best of your ability

PATIENT INFORMATION

PATIENT NAME _____ BIRTH DATE _____ SOCIAL SEC. #: _____ SEX: M F

SPOUSE NAME _____ BIRTH DATE _____ SOCIAL SEC. #: _____ SEX: M F

CURRENT ADDRESS _____
STREET CITY STATE ZIP

CELL PHONE ( ) _____

HOME PHONE ( ) _____ E•MAIL: _____ MARITAL STATUS: ❑ MARRIED ❑ SINGLE ❑ SEPARATED ❑ DIVORCED ❑ WIDOWED

IF PATIENT IS A CHILD:

PARENT/GUARDIAN NAME _____ BIRTHDATE _____ SOCIAL SEC.# _____

ADDRESS _____ PHONE _____

OTHER PARENT/GUARDIAN NAME _____ BIRTHDATE _____ SOCIAL SEC.# _____

ADDRESS (IF DIFFERENT) _____ PHONE (IF DIFFERENT) _____

IS PATIENT CURRENTLY IN A SKILLED NURSING FACILITY OR HOSPICE CARE? Y N

NAME: PHONE:

ADDITIONAL INFORMATION

REFERRING M.D. _____ PHONE _____ FAMILY M.D. _____ PHONE _____

PATIENT'S/PARENT'S EMPLOYER _____ OCCUPATION _____

ADDRESS OF EMPLOYER _____ PHONE _____

SPOUSE'S EMPLOYER _____ OCCUPATION _____

ADDRESS OF EMPLOYER _____ PHONE _____

NAME OF CHILDREN AT HOME:

1. _____ BIRTH DATE _____ SEX: 3. _____ BIRTH DATE _____ SEX:

2. _____ BIRTH DATE _____ SEX: 4. _____ BIRTH DATE _____ SEX:

NEXT OF KIN: (Someone who does not live with you, in case of emergencies)

NAME _____ RELATIONSHIP _____

ADDRESS _____ PHONE _____

INSURANCE INFORMATION

1. WE NEED TO MAKE A COPY OF YOUR INSURANCE CARD(S).
2. DOES YOUR INSURANCE REQUIRE: ❑ REFERRAL NUMBER ❑ PRECERTIFICATION ❑ SECOND OPINION
3. IF MEDICARE:
   - ARE YOU EMPLOYED FULL TIME? Y N
   - IS GROUP INSURANCE AVAILABLE? Y N
   - SPOUSE EMPLOYED? Y N
   - ARE YOU DISABLED? Y N
   - IS GROUP INSURANCE AVAILABLE? Y N
4. DO YOU HAVE A MEDICARE HMO? Y N

PRIMARY COVERAGE

(Usually the Patient's Insurance)

NAME OF INS. CO. _____

POLICYHOLDER _____

PATIENT RELATIONSHIP TO POLICYHOLDER: ❑ SELF ❑ SPOUSE

❑ CHILD ❑ OTHER _____

MEMBER ID # _____

GROUP ACCOUNT # _____

EFFECTIVE DATE _____

PHONE # TO VERIFY BENEFITS _____

PHONE # FOR PRECERTIFICATION _____

SECONDARY COVERAGE

(The spouse's insurance is secondary if patient has insurance coverage)

NAME OF INS. CO. _____

POLICYHOLDER _____

PATIENT RELATIONSHIP TO POLICYHOLDER: ❑ SELF ❑ SPOUSE

❑ CHILD ❑ OTHER _____

MEMBER ID # _____

GROUP ACCOUNT # _____

EFFECTIVE DATE _____

PHONE # TO VERIFY BENEFITS _____

PHONE # FOR PRECERTIFICATION _____

PLEASE SIGN AUTHORIZATION STATEMENT ON BACK

I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE BENEFITS AND MEDIGAP BENEFITS BE MADE ON MY BEHALF TO THE PHYSICIANS OF UROLOGY OF INDIANA FOR ANY SERVICES THEY PROVIDE TO ME. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE HEALTH CARE FINANCING ADMINISTRATION AND ITS AGENTS ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES.

I HEREBY AUTHORIZE THE PHYSICIANS OF UROLOGY OF INDIANA TO APPLY FOR BENEFITS ON MY BEHALF FOR SERVICES RENDERED TO ME BY THEM OR BY THEIR ORDERS.

I REQUEST THAT PAYMENT OF AUTHORIZED INSURANCE BENEFITS BE MADE ON MY BEHALF TO THE PHYSICIANS OF UROLOGY OF INDIANA FOR ANY SERVICES THEY PROVIDE TO ME. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME, TO RELEASE, TO THE INSURANCE COMPANY ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES.

I HEREBY AUTHORIZE THIS OFFICE TO RELEASE ANY INFORMATION ACQUIRED TO ESTABLISH A HEALTH INSURANCE CLAIM. I AUTHORIZE THIS OFFICE TO OBTAIN PREVIOUS MEDICAL RECORDS FROM OTHER PHYSICIANS AND/OR MEDICAL FACILITIES, INCLUDING BUT NOT LIMITED TO INFORMATION REGARDING TREATMENT OF DRUG OR ALCOHOL ABUSE, PSYCHOLOGICAL CONDITIONS, HIV TESTING OR AN AIDS RELATED CONDITION.

I UNDERSTAND THAT I AM PERSONALLY RESPONSIBLE FOR ALL CHARGES INCLUDING DEDUCTIBLES, CO-PAYS, NON COVERED SERVICES AND ANY AMOUNT NOT COVERED BY MY INSURANCE (EXCEPT IN CASES OF A CONTRACTUAL AGREEMENT BETWEEN MY INSURANCE CARRIER AND MY PHYSICIAN). I UNDERSTAND THAT THE CHARGES I AM RESPONSIBLE FOR ARE TO BE PAID AT THE TIME OF SERVICE. SHOULD COLLECTION PROCEEDINGS BECOME NECESSARY, I UNDERSTAND THAT I WILL BE RESPONSIBLE FOR REASONABLE ATTORNEY FEES, COURT COST AND ALL COLLECTION COST.

I AUTHORIZE MY HEALTH CARE PROVIDER TO USE AN AUTOMATED TELEPHONE SYSTEM AND/OR E-MAIL TO USE MY NAME, ADDRESS, AND PHONE NUMBER; THE NAME OF MY SCHEDULED TREATING PHYSICIAN; AND THE TIME AND PLACE OF MY SCHEDULED APPOINTMENT(S), FOR THE LIMITED PURPOSE OF CONTACTING ME TO NOTIFY ME OF A PENDING APPOINTMENT OR OTHER HEALTH CARE RELATED COMMUNICATION. I ALSO AUTHORIZE MY HEALTH CARE PROVIDER TO DISCLOSE TO THIRD PARTIES WHO ANSWER MY PHONE LIMITED PROTECTED HEALTH INFORMATION REGARDING PENDING APPOINTMENTS, AND TO LEAVE A REMINDER MESSAGE ON MY VOICE MAIL SYSTEM OR ANSWERING MACHINE.

I HAVE RECEIVED A COPY OF THE UROLOGY OF INDIANA NOTICE OF PRIVACY PRACTICES.

IN THE CASE OF CHILDREN WHOSE RESPONSIBLE PARTY IS SOMEONE OTHER THAN THE CUSTODIAL PARENT, WE ASK THAT PAYMENT BE MADE AT THE TIME OF SERVICE BY THE PERSON ACCOMPANYING THE CHILD.

SIGNATURE - PATIENT/REPRESENTATIVE _____ DATE _____

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