NEW PATIENT REGISTRATION FORM

Please print clearly and fill out completely. Rev 3/2017

Patient Name: Date of birth: Sex:

Mailing Address: City State: Zip code:

Alternate Address:

Phone # Home: Work: Cell:

Marital Status: Social Security #:

OK to leave message (Circle all that apply)
Home Work Cell

Primary Care Physician: **Email:**

Pharmacy (name and cross streets):

Employer name: _____ ❑ Full Time ❑ Part Time ❑ Retired ❑ Unemployed

Are you covered by medical insurance? ❑ Yes ❑ No

Primary Insurance: Secondary:

Primary Cardholder: ❑ Self ❑ Spouse ❑ Parent ❑ Other

Cardholder Name: Sex: DOB:

Emergency Contact: Relation: Phone:

Patient Privacy of Medical Information (HIPPA RELEASE)
***I am aware a copy of the Patient Privacy Act is available to me upon request*.**
To ensure the confidentiality of your medical information, it is required that you authorize release of this information to persons other than you. Please indicate below the name of alternative parties (if any) you would like to have access to your information.
I hereby authorize the release of medical information to:

Name:_____Relation:_____Phone:_____

To notate no one to have access to your information check here ☐
My designated alternative party will remain the same unless a change is requested by me in writing. I acknowledge that I have been provided with and read the Patient Privacy Act.

Patient Signature:_____ Date:_____

Note: Upon patient request for medical records, a copy will be provided at no charge. Additional requests will mandate a $25 service fee. Our electronic medical records may require use of software from multiple vendors. Errors may occur in data, context, spelling, grammar, or information due to software.

Medicare Patients Only
I request that payment of authorized Medicare benefits be made either to me or on behalf of Southwest Urologic Specialists, PC. for any service furnished me by that physician. I authorize any holder of medical information about me to release to HCFA and its agents needed to determine these benefits payable for related services. I understand my signature request that be made and authorize release of medical information necessary to pay claim. In Medicare assigned cases, the physician agrees to accept the charge determination of the Medicare carrier as full charge and the patient is responsible only for deductible coinsurance and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier.

Signature of Insured:_____ Date: _____

Release and Assignment
I, the undersigned, have insurance through _____ and assign directly to Southwest Urologic Specialists, PC. all medical benefits, if any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by said insurance unless assignee has executed an agreement with my insurance carrier or plan. I understand that if such agreement has been executed I am responsible to pay any deductible and/or copayment and non-covered services under the terms of my insurance. I understand that any payments which are due starting 30 days after insurance coverage had been completed will be charged a $15 monthly late service charge (OR) at a rate of 1.5% interest per month based on the unpaid balance, whichever is greater. I understand that I am financially liable in the event of non-payment. I agree to pay the collection agency's cost (40%) and/or court cost and reasonable attorney fees. There will be a $35 charge upon the request for the completion of disability and work-release forms (family & medical leave).

Signature of Insured or Guardian_____ Date:_____