THE UROLOGY INSTITUTE AND CONTINENCE CENTER, PC

PATIENT REGISTRATION FORM

NAME _____ **SS#** _____
Last Name, First Name, MI

AGE _____ **BIRTHDATE** _____ **MALE** ____ **FEMALE**____ **RACE** _____
MM/DD/YYYY

HM PHONE: _____ **WK PHONE:**_____ **CELL PHONE:** _____

MAILING ADDRESS: _____

PHYSICAL ADDRESS: _____

CITY: _____ **COUNTY:** _____ **STATE:** _____ **ZIP CODE**_____

EMPLOYER'S NAME & ADDRESS: _____

ER CONTACT PERSON: _____ **RELATIONSHIP:** _____

HM PHONE: _____ **WK PHONE:**_____ **CELL PHONE:** _____

NAME OF PERSON RESPONSIBLE FOR ACCOUNT <u>IF OTHER THAN PATIENT</u>:

INSURANCE INFORMATION

PLEASE PROVIDE A COPY OF YOUR PRIMARY AND SECONDARY INSURANCE CARD(S) AND A VALID FORM OF IDENTIFICATION. <u>WE ARE NOT WORKER'S COMPENSATION PROVIDERS.</u>

NAME OF INSURED: _____ **RELATIONSHIP:** _____

I authorized consent for medical treatment and services. I authorized the release of medical/financial information necessary to process claims and assignment of benefits to the provider of services. I request that payment of authorized Medicare / Private / Commercial Insurance benefits be made directly to **The Urology Institute and Continence Center** and / or **Urology Institute Ambulatory Surgery Center** for services furnished to me by that party. I understand that I am responsible for any non-covered services or balance on my account not payable by my insurance company. Failure to pay the fee for non-covered services or balance on my account may result in legal actions necessary for collection. Any cost incurred by such action will be the responsibility of the patient / responsible party. I fully understand my responsibilities and attest this information is true and correct to the best of my knowledge.

_____ _____
Signature of Adult patient / Responsible Party **Today's date**