



PATIENT REGISTRATION – DEMOGRAPHICS

Assigned UA Physician

PATIENT INFORMATION					
Last Name		First Name		M.I.	Nickname
SSN	Sex <input type="checkbox"/> Female <input type="checkbox"/> Male	Date of Birth		Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	
Race/Ethnicity <input type="checkbox"/> I decline to answer <input type="checkbox"/> African-Amer. <input type="checkbox"/> Asian <input type="checkbox"/> Caucasian <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Amer. <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Other				Preferred Language <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other:	
Street Address					Apt #
City			State	Zip	
Preferred Contact: <input type="checkbox"/> Home # <input type="checkbox"/> Work # <input type="checkbox"/> Cell # <input type="checkbox"/> Email		Home Phone # ()	Work Phone # ()	Cell Phone # ()	Email Address
Referring Physician	Referring Physician Phone ()		Primary Care Physician		Employer Name <input type="checkbox"/> n/a
EMERGENCY CONTACT INFORMATION					
Name		Relationship to Patient: <input type="checkbox"/> Spouse/Partner <input type="checkbox"/> Friend <input type="checkbox"/> Parent <input type="checkbox"/> Other:		Phone <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work ()	Phone <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work ()
GUARANTOR (Financially-responsible party)					
Name (<input type="checkbox"/> same as patient)		Relationship to Patient: <input type="checkbox"/> Parent/Guardian <input type="checkbox"/> Power of Atty. <input type="checkbox"/> Other:		Phone <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work ()	Phone <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work ()
Street Address					Apt #
City			State	Zip	
INSURANCE INFORMATION					
<i>Primary Insurance</i> <input type="checkbox"/> no insurance or wish to self-pay			<i>Secondary Insurance</i> <input type="checkbox"/> none		
<input type="checkbox"/> Private Policy <input type="checkbox"/> Group Policy (Employer) <input type="checkbox"/> TriCare (ChampUS) <input type="checkbox"/> Medicare (Part B) <input type="checkbox"/> Medicaid <input type="checkbox"/> Indemnity Plan <input type="checkbox"/> Worker's Comp <input type="checkbox"/> Other			<input type="checkbox"/> Private Policy <input type="checkbox"/> Group Policy (Employer) <input type="checkbox"/> TriCare (ChampUS) <input type="checkbox"/> Medicare (Part B) <input type="checkbox"/> Medicaid <input type="checkbox"/> Indemnity Plan <input type="checkbox"/> Worker's Comp <input type="checkbox"/> Other		
Insurance Name/Plan			Insurance Name/Plan		
Insurance/Member ID #			Insurance/Member ID #		
Group # <input type="checkbox"/> n/a			Group # <input type="checkbox"/> n/a		
Claim # <input type="checkbox"/> n/a			Claim # <input type="checkbox"/> n/a		
Subscriber Name <input type="checkbox"/> patient = subscriber			Subscriber Name <input type="checkbox"/> patient = subscriber		
Subscriber DOB		Subscriber SSN		Subscriber DOB	
				Subscriber SSN	
OTHER INFORMATION					
Are you a resident of a nursing home facility? <input type="checkbox"/> Yes <input type="checkbox"/> No <small>(If Yes, patient must be accompanied by an informed caregiver)</small>			Are you registered for Home Health Care? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Facility Name			What is your preferred pharmacy for prescriptions?		
Facility Phone ()			Do you have a mail order or second pharmacy for prescriptions? Please provide name.		

Patient/Guardian Signature: _____

Date Signed: _____



FINANCIAL POLICY NOTICE

Please read carefully. Initial where indicated and then sign at the bottom.

(Initial) Insurance co-pays are due **at the time of service** and before you see the doctor. **If you are unable to pay your co-pay you may be asked to reschedule your appointment.** Due to the fact that Urology Austin physicians are specialists, higher co-pays may be indicated (consult your policy benefits for clarification).

(Initial) CT scans and in-office surgical procedures are typically applied by your insurance company towards your deductible, co-insurance or other out-of-pocket expense. **All fees are due in advance of the CT or surgical procedure performed** unless an alternate arrangement is made *prior to* your appointment date. **Outside radiologist fees usually apply for your scan. Please pay close attention to your CT information.**

(Initial) If at any time you have a credit on your account, refunds may only be remitted to you *after* all pending insurance claims have been finalized by your insurance company and reported to us.

(Initial) Many insurance plans cover ancillary services (labs, x-rays, CT scans, etc.) under alternate benefits, such as higher deductible or co-insurance amounts, even additional co-pays. These additional out-of-pocket expenses are not associated with our contract/participation with your insurance company. Instead, it is simply a matter of your plan benefits. Urology Austin must comply with both contractual obligations and government regulations, **thus we cannot alter your insurance plan benefits and will bill you accordingly.**

(Initial) It is the patient’s responsibility to know from whom your insurance company requires that you to obtain any labs, x-rays, or any other ancillary services. Please let your doctor’s medical assistant or nurse know so that they may schedule these services accordingly.

(Initial) It is the patient’s responsibility to obtain all referral certifications from the primary care or referring physician when required by your insurance plan. **If you do not have a current referral on file, you will be asked to reschedule your appointment.**

(Initial) Laboratory services cannot be billed until the date the test is performed which may be a different day than when you came to give your sample. Thus, the date on your billed statements (from Urology Austin or your insurance company) may be different from the actual date you were in the office. **Outside laboratory charges may also apply—ask an associate for more info if you will be having lab services.**

(Initial) If we do not participate with your insurance company, and your insurance plan does not provide out-of-network benefits, you will be considered a “self-pay” patient. See the Self-Pay Patient policy below. As a courtesy, we shall provide you with the information necessary to bill your insurance company.

SELF-PAY PATIENTS

(Initial) If you (1) do not have insurance coverage, (2) choose not to use your insurance coverage, or (3) are seeking treatment/services that are not covered by your insurance plan, you are a “self-pay” patient. Upon arrival at your visit you are required to provide a deposit (\$250 for new patients and \$150.00 for already established returning patients). As you leave, you must pay for any remaining balance for the services provided. A 30% discount of our regular fees will be applied.

Urology Austin accepts cash, checks, MasterCard, VISA, Discover Card and American Express. Additional fees may apply to special financing arrangements and bad debt collections.

By signing this Financial Policy Notice you, the guarantor, acknowledge that you have read, understand and accept the above financial policy. (Additional financial obligations may apply to special services. You will be presented more information as they apply to your treatment plan.)

Guarantor Signature: _____ Date: _____

Name of Guarantor (if different from patient): _____

Patient name: _____ DOB _____ Date _____

Medical History Form

Reason for Visit Today: _____

MEDICAL ALLERGIES (include dye, etc): _____

CURRENT MEDICATIONS (If additional → Complete on back)

Name	Dose	How often per day	Reason for taking	Name	Dose	How often per day	Reason for taking

PAST MEDICAL HISTORY (Urologic) - Please circle as appropriate

- | | | | |
|----------------------|---------------------------------|---------------------------------------|--------------------------|
| Erectile Dysfunction | Elevated PSA | Enlarged prostate (BPH) | Hypogonadism – “Low T” |
| Kidney stones | Urinary retention | Blood in urine (hematuria) | Urinary Tract Infections |
| Prostate Cancer | Bladder Cancer | Kidney Cancer | Testicular cancer |
| Renal Failure | Incontinence (leakage of urine) | Pelvic prolapse(cystocele, rectocele) | |

Other: _____

PAST MEDICAL HISTORY (Non-urologic) – Please circle as appropriate

- Head, Ears, Eyes, Nose, Throat: Blindness Cataracts Deafness Glaucoma
 Cardiovascular: Heart attack (MI) Hypertension Atrial Fibrillation
 Congestive Heart Failure Angina
 Respiratory: Asthma COPD Emphysema Pulmonary Embolism(PE)
 Gastrointestinal: Crohn’s Disease Diverticulitis Hepatitis GERD (reflux)
 Endocrine: Diabetes Gout Hypothyroidism Hyperthyroidism
 Neurological: Alzheimer’s Dz Stroke Parkinson’s Dz Multiple sclerosis
 Cancer: Breast Colon Lung Lymphoma Ovarian

Other medical conditions

Other cancer diagnosis: _____

Infectious/Hematologic: Anemia HIV/AIDS Tuberculosis Deep venous thrombosis (DVT)

PAST SURGICAL HISTORY (Urologic and Gynecologic) - Please circle as appropriate

- | | |
|---|--|
| Robotic Prostatectomy | Open Radical Prostatectomy |
| Nephrectomy – Open or Laparoscopic | Partial Nephrectomy – Open or Laparoscopic |
| TURP (surgery for enlarged prostate) | TURBT (removal of bladder tumor) |
| ESWL (sound wave treatment of kidney stones) | Ureteroscopy – laser or basket removal of stones |
| Orchiectomy (removal of testicle) | Pyeloplasty (for UPJ obstruction) |
| Prostate Needle Biopsy | Endoscopic treatment of urethral stricture |
| Pelvic Prolapse repair (cystocele, enterocele, rectocele repair – with or without mesh) | |

Bladder sling for incontinence Bladder suspension for incontinence Hysterectomy

Dates of Surgery/Procedure circled above: 1) _____
 (or other surgeries) 2) _____





Baker, Brett W MD
 Bischoff, Carl J MD
 Bruce, R Grady MD
 Cuellar, David C MD
 Desireddi, Naresh MD

Floyd, Michael K MD
 Freidberg, David W MD FACS
 Garza, Richard P MD
 Greenwell, David P MD
 Horan, John J MD FACS

Kocureck, Jeffrey N MD
 Maloney, Shaun A MD
 McClelland, Michael L Jr MD
 Northway, Robert O III MD
 Phillips, David L MD

Pickett, Steven MD PhD
 Putzi, Mathew J MD
 Ruff, Peter A MD
 Singh, Herb MD
 Williamson, John C MD

**CONSENT TO RELEASE PROTECTED HEALTH INFORMATION
 & ASSIGNMENT OF BENEFITS**

_____ I have read and acknowledge Urology Austin’s Notice of Privacy Practices. Urology Austin
 (Initial) complies with all regulatory guidelines with regard to safeguarding your protected health information (PHI). For example, sharing of my PHI may only occur between authorized entities such as my insurance company and my physician, but not with my spouse. These guidelines and our policies are published in this Notice. A copy for my records will be provided at my request.

_____ I authorize my primary care physician, referring physician and other care providers to furnish
 (Initial) any and all information concerning my present illness or injury to Urology Austin.

_____ I authorize Urology Austin to leave information and appointment reminders at the following:
 (Initial) Home Phone: _____ Work Phone: _____
 Cell Phone: _____ Email Address: _____

Please list any authorized entities with whom we can share your PHI: None

Name: _____ Relationship _____

Name: _____ Relationship _____

Name: _____ Relationship _____

ASSIGNMENT OF BENEFITS

I authorize assignment of my insurance plan benefits directly to Urology Austin for services provided. I understand that I am financially responsible to Urology Austin for all cost-share expenses (co-pay, co-insurance and deductible), as well as any services not covered by my insurance plan.

 Patient Name

 Patient DOB

 Patient Signature

 Date Signed

 Guarantor Signature (if different than patient)

 Date Signed