

PATIENT REGISTRATION FORM

2010

**Today's Date:

Clinic Name:

ASSOCIATED UROLOGIST 192

PATIENT INFORMATION: (Please use full legal name, no nicknames)

*Last Name: *First Name: Middle Initial:

*Address:

City: State: Zip:

Home Phone #: () - *Social Security #:

*Date of Birth: Age: *Sex: Marital Status: Drivers Lic#:

*Employer Name and Address:

Work Phone #: () -

E-mail Address: Cell Phone #: () -

Emergency Contact Name: Emerg Phone #: () -

Please tell us how you heard about us:

Referred by

GUARANTOR INFORMATION: (List person or insured name responsible for bill - use full legal name, no nicknames)

*Relationship of Guarantor to Patient: Self Spouse Parent Other

*Last Name: *First Name: Middle Initial:

*Address:

City: State: Zip:

Home Phone #: () - *Social Security #:

*Date of Birth: Age: *Sex: Female Male

*Employer Name and Address:

Work Phone #: () -

INSURANCE INFORMATION: (Please allow receptionist to photocopy your insurance ID cards)

IF SOMEONE OTHER THAN PATIENT IS THE INSURED PARTY, PLEASE INCLUDE DATE OF BIRTH FOR CLAIMS

PRIMARY INSURANCE:

Plan Name: *Insured's Name:

Insured's Social Security #: *Insured's Date of Birth:

*Policy / ID #: *Group #: Eff Date:

Claims Address & Phone:

SECONDARY INSURANCE:

Plan Name: *Insured's Name:

*Insured's Social Security #: *Insured's Date of Birth:

*Policy / ID #: *Group #: * Eff Date:

Claims Address & Phone:

*REQUIRED FIELDS-PLEASE COMPLETE FOR BILLING.

*ATTACH COPY OF INSURANCE CARDS.

Please read and sign back of form.

ASSOCIATED UROLOGISTS, P.A.

ADULT & PEDIATRIC UROLOGY • IMPOTENCY & INFERTILITY

(972) 270-8859 Answered 24 Hours • Fax (972) 279-5551

PRESCRIPTION REFILL PROCESS

When you need a prescription refill:

1. Call your pharmacy and request the refill (regardless of the number of refills left on your bottle). Please allow 72 hours for Associated Urologists to process your request from your pharmacy.
2. If it has been over 90 days since you were last seen by your Associated Urologists Physician, please call for a follow-up Appointment prior to your medication refill.

NON-CANCELLATION POLICY

In an effort to improve the quality of care we want to provide to all of our patients, there will be a **\$35.00** office charge for patients who miss their appointments without a 24-hour advanced notice to our office. It is our belief this policy will minimize the amount of valuable unused appointment time that could have been given to our patients with acute illnesses. We strive to provide all our patients the best care possible and we believe this policy will move us closer to our goal.

ANCILLARY SERVICES

I acknowledge that my treating physician may have financial interest in the ancillary services. I further understand that I am free to choose where I receive medical services and that I may discuss with my physician the availability of alternative treatment facilities if I so desire.

Thank you for your help in making Associated Urologists a most effective Patient Care Facility.

Associated Urologists Physicians and Staff

Patient Signature _____ Date _____

Guardian Signature _____ Date _____

Associated Urologists

Acknowledgement of Receipt of HIPAA Notice of Privacy Practices

This practice reserves the right to modify the privacy practices outlined in the notice.

I have received a copy of the "Notice of Privacy Practices"

Name of Patient (Print)

Signature of Patient

Date of Signature

Signature of Patient Representative

(Required if the patient is a minor or an adult who is unable to sign this form)

Relationship of Patient Representative to Patient

Request for Confidential Communication of Your Protected Health Information

Please circle your response to the following:

May we leave messages concerning your **appointments** with a co-worker, receptionist or secretary that regularly answer your calls? Yes No N/A

May we leave **messages** on a voice mail at work? Yes No N/A

May we discuss your **appointments/treatment** with your spouse? Yes No N/A

If you are over the age of 18, still living at home, may we discuss your **appointments/treatment** with your parent(s) or guardian? Yes No N/A

If you are over the age of 18, may we discuss your **appointments and/or treatment** with your children? Yes No N/A

You must inform us **in writing** if you wish to change the manner in which this office communicates to you.

Thank you.

Please place in the patient's medical record.

12/06

**Associated Urologists
841 Wheatfield Dr. Ste. 100
Sunnyvale, TX 75182**

Clinic: _____

FINANCIAL RESPONSIBILITY AGREEMENT

Patient
Name: _____

Date
of Birth: _____

Date
of Visit: _____

I understand and agree that I will be financially responsible for any and all charges for services not paid by my insurance for my visits. This includes any Medical service or visit, Preventative exam or physical, Lab testing, X-ray, EKG, and any other Screening service or Diagnostic testing ordered by the physician or the physician's staff.

I understand and agree it is my responsibility and not the responsibility of the Physician or Clinic to know if my insurance will pay for my Medical service or visit, Preventative exam or physical, Lab testing, X-ray, EKG, or any other Screening service or Diagnostic testing ordered by the physician or the physician's staff.

I understand and agree it is my responsibility to know if my insurance has any Deductible, Co-payment, Co-insurance, Out-of-Network amount, Usual and Customary Limit, or any other type of benefit limitation for the services I receive, and I agree to make full payment.

I understand and agree it is my responsibility to know if the physician or provider I am seeing is a contracted in-network provider recognized by my insurance company or plan. If the physician or provider I am seeing is not recognized by my insurance company or plan, it may result in claims being denied or higher out of pocket expense to me. I understand this and agree to be financially responsible and make full payment.

I understand and agree it is my responsibility to know if my PCP choice has been processed by my Insurance company or plan. If I have requested a PCP change that is not processed by my insurance company, it may result in claims being denied. I understand this and agree to be financially responsible and make full payment.

Signature: _____
(please sign here - Patient or Responsible Party)

Date: _____

Responsible
Party Name: _____
(please print name of Responsibility Party if different from Patient)

Review of Systems

Do you now or have you recently had any problems related to the following systems? Circle **Yes** or **No**.

Constitutional Symptoms

| | | |
|-------------|---|---|
| Fever | Y | N |
| Chills | Y | N |
| Headache | Y | N |
| Other _____ | | |

Eyes

| | | |
|----------------|---|---|
| Blurred vision | Y | N |
| Double vision | Y | N |
| Pain | Y | N |
| Other _____ | | |

Allergic/Immunologic

| | | |
|----------------|---|---|
| Hay Fever | Y | N |
| Drug allergies | Y | N |
| Other _____ | | |

Neurological

| | | |
|-------------------|---|---|
| Tremors | Y | N |
| Dizzy spells | Y | N |
| Numbness/tingling | Y | N |
| Other _____ | | |

Endocrine

| | | |
|------------------|---|---|
| Excessive thirst | Y | N |
| Too hot/cold | Y | N |
| Tired/sluggish | Y | N |
| Other _____ | | |

Gastrointestinal

| | | |
|---------------------------|--------------|--------------|
| Abdominal pain | Y | N |
| Nausea/vomiting | Y | N |
| Indigestion/heartburn | Y | N |
| Other _____ | | |

Cardiovascular

| | | |
|---------------------|---|---|
| Chest pain | Y | N |
| Varicose veins | Y | N |
| High blood pressure | Y | N |
| Other _____ | | |

Physician use only: (Comments/Notes)

Integumentary

| | | |
|-----------------|---|---|
| Skin rash | Y | N |
| Boils | Y | N |
| Persistent itch | Y | N |
| Other _____ | | |

Musculoskeletal

| | | |
|-------------|---|---|
| Joint pain | Y | N |
| Neck pain | Y | N |
| Back pain | Y | N |
| Other _____ | | |

Ear/Nose/Throat/Mouth

| | | |
|---------------|---|---|
| Ear infection | Y | N |
| Sore throat | Y | N |
| Sinus problem | Y | N |
| Other _____ | | |

Genitourinary

| | | |
|-------------------|---|---|
| Urine retention | Y | N |
| Painful urination | Y | N |
| Urinary frequency | Y | N |
| Other _____ | | |

Respiratory

| | | |
|---------------------|---|---|
| Wheezing | Y | N |
| Frequent cough | Y | N |
| Shortness of breath | Y | N |
| Other _____ | | |

Hematologic/Lymphatic

| | | |
|---------------------------|--------------|--------------|
| Swollen glands | Y | N |
| Blood clotting problem | Y | N |
| Other _____ | | |

Psychologic

| | | |
|---|---|---|
| Are you generally satisfied with your life? | Y | N |
| Do you feel severely depressed? | Y | N |
| Have you considered suicide? | Y | N |
| Other _____ | | |

Physician: _____ Date: _____