

REGISTRATION FORM

PATIENT NAME _____ Age _____ Date of Birth _____

LAST FIRST MI

MALE FEMALE MARITAL STATUS: (please circle) SINGLE MARRIED DIVORCED SURVIVING SPOUSE (please circle)

ADDRESS _____ HOME PHONE (____) _____

STREET

WORK PHONE (____) _____

CITY

STATE

ZIP

EXT

SOCIAL SECURITY # _____ CELL PHONE (____) _____

EMPLOYER: _____ OCCUPATION _____ DEPT _____

ADDRESS _____

Are you in HOSPICE? _____ Do you live in a Nursing Home? _____ Name of Nursing Home _____

Address of Nursing Home _____

EMERGENCY CONTACT: NAME _____ HOME PHONE # _____ WORK PHONE # _____

Relationship to patient _____ ADDRESS _____

ADDRESS

HUSBAND/WIFE INFORMATION: NAME _____ DATE OF BIRTH _____

or PARENT if patient is a child

SOCIAL SECURITY # _____ EMPLOYER _____ OCCUPATION _____ DEPT _____

ADDRESS _____

PERSON RESPONSIBLE FOR CHARGES? _____ NAME _____ HOME PHONE _____ WORK PHONE _____

(If patient has a legal GUARDIAN)

NAME

HOME PHONE

WORK PHONE

ADDRESS

INSURANCE INFORMATION

PRIMARY INSURANCE #1 _____ POLICY # _____ GROUP# _____

(File this claim first)

SUBSCRIBER'S NAME _____

address

EMPLOYER _____

** SUBSCRIBER'S DATE OF BIRTH _____

address

SECOND INSURANCE #2 _____ POLICY # _____ GROUP # _____

(File this claim second)

SUBSCRIBER'S NAME _____

address

** SUBSCRIBER'S DATE OF BIRTH _____

address

FAMILY PHYSICIAN _____ REASON FOR APPOINTMENT _____

LAST NAME

FIRST NAME

REFERRING PHYSICIAN _____ ADDRESS _____

LAST NAME

FIRST NAME

ADDRESS

DRUG ALLERGIES _____ LATEX ALLERGY? _____

PHARMACY _____ PHONE # _____

WOULD YOU BE INTERESTED IN PARTICIPATING IN CLINICAL RESEARCH? __ YES __ NO

PLEASE SIGN ON REVERSE SIDE

Today's Date ___/___/___

Providing quality medical care for our patients is our primary concern. We are more than willing to provide that care within your insurance contract guidelines if you let us know at each time of service exactly what those guidelines are. Unfortunately, if you do not inform us of any special requirement in your contract and we subsequently order services, such as lab work, x-rays, or hospitalization, that are not covered, we or the selected medical facility will have no choice but to bill you directly for those charges. Payments for those charges is then your responsibility. As the policy holder, YOU ARE RESPONSIBLE for knowing the benefits and restrictions of your insurance coverage.

WAIVER: I understand that should my insurance company require a REFERRAL/AUTHORIZATION prior to my receiving Medical Service and I have not obtained this and/or this office has not received this, I WILL BE RESPONSIBLE FOR ALL CHARGES INCURRED.

I understand that should it become necessary to place my account with an outside collection agency there will be an **additional 30% penalty** added to my delinquent balance.

I HAVE READ AND UNDERSTAND THE OFFICE POLICY STATED ABOVE AND AGREE TO ACCEPT RESPONSIBILITY AS DESCRIBED.

SIGNATURE _____ DATE _____

* A \$25.00 CHARGE WILL BE COLLECTED FOR ALL RETURNED CHECKS.

MEDICARE LIFETIME SIGNATURE ON FILE

NAME OF BENEFICIARY _____

HIC NUMBER _____

I request that payment of authorized Medicare benefits be made either to me or on my behalf to TRI STATE UROLOGIC SERVICES, P.S.C., INC. for any services furnished me by TRI STATE UROLOGIC SERVICES, P.S.C., INC. or their contracted agents PeriOp Anesthesia, P.S.C. or Professional Radiology Inc. or Southern Ohio Pathology. I authorize any holder of medical information about me to release to the Center for Medicare/Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If item 9 of the HCFA-1500 claim form is completed, my signature authorizes releasing of the information to the insurer or agency shown. In Medical assigned cases, the physician agrees to accept the charge determination of the Medical carrier as the full charge and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier. In Medicare nonassigned cases, the patient is responsible for the entire charge.

SIGNATURE OF PATIENT _____ DATE _____

WITNESS IF SIGNED WITH AN "X" _____