Patient Registration Form *Please Print All Information*

Patient's Name: (First)_____(Middle)_____(Last)_____

Date of Birth:_____/_____/_____ Age:_____ ☐ Male ☐ Female SS#_____

Mailing Address: _____ Apt./ Lot #:_____

City:_____ State:_____ Zip:_____ Email:_____

Main Phone # ( )_____ Alternate Phone # ( )_____

Preferred Language: ☐ English ☐ Spanish ☐ Arabic ☐ Other _____

Race: ☐ African American ☐ Caucasian ☐ Hispanic ☐ Asian ☐ Native American ☐ Other_____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Referring Physician: _____ Phone # ( )_____

Primary Care Physician: _____ Phone # ( )_____

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated

Spouse's Name:_____Date of Birth:_____/_____/_____Phone # ( )_____

Emergency Contact: _____ Relationship:_____Phone # ( )_____

Employment Status: ☐ Full-Time ☐ Part-Time ☐ Unemployed ☐ Disabled ☐ Retired ☐ Student

Employer: _____ Occupation_____ Phone # ( )_____

Insurance Information

Primary Insurance: _____ Policy Holder:_____ Date of Birth:____/____/___

Secondary Insurance: _____Policy Holder_____Date of Birth:____/____/___

Assignment to Pay Insurance Benefits

I hereby assign all medical and/or surgical benefits, to which I am entitled, including Medicare, private insurance and any other health plans to University Urology, PC. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure this payment. I understand that failure to notify University Urology of any changes or insurance coverage will result in the financial obligation to rest fully on myself regardless of any contact between the insurance company and University Urology.

ePrescribing is defined as a physician's ability to electronically send an accurate, error-free and understandable prescription to a pharmacy from the point of care. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. ePrescribing greatly reduces medication errors and enhances patient safety. By signing this consent form, you are agreeing that University Urology can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payer for treatment purposes. Understanding all of the above, I hereby provide informed consent to University Urology, P.C. to enroll me in the ePrescribe Program.

Signature: _____ Date:_____

Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística.

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University Urology, PC

PERSONAL HEALTH INFORMATION

_____

Name | Date of Birth | Today's Date

_____

Pharmacy Name | Pharmacy Phone Number

_____

Pharmacy Address | City | State | Zip

_____

Primary Care Physician | Primary Care Physician Phone Number

Height: _____ft _____in **Weight**: _____lbs

DO YOU HAVE ANY DRUG ALLERGIES? If so, please list below:

Medication	What was your reaction?

Are you allergic to IV Dye*? _____YES _____NO* ***Are you allergic to Shellfish****? _____YES _____NO*

DO YOU CURRENTLY TAKE ANY BLOOD THINNERS OR ASPIRIN? _____*YES* _____*NO*

If you answered YES, please make sure to write in the name, dose, and how often you take this medication.

Please List Current Prescription Medications	**Dose** (strength)	**How Often** (ex: once daily)

University Urology, PC

AUTHORIZATION TO RELEASE INFORMATION

Per HIPAA requirements, we are not allowed to give medical information to anyone without the patient's consent. Signing this form will give consent to release appointment information, test/procedure results, and/or financial information to the contacts you list below.

I authorize University Urology, PC to release my medical and/or financial information to the following individual(s):

Name:_____ Phone#_____

Relationship:_____

☐ MEDICAL AND FINANCIAL ☐ MEDICAL ONLY ☐ FINANCIAL ONLY

Name:_____Phone#_____

Relationship:_____

☐ MEDICAL AND FINANCIAL ☐ MEDICAL ONLY ☐ FINANCIAL ONLY

Name:_____Phone#_____

Relationship:_____

☐ MEDICAL AND FINANCIAL ☐ MEDICAL ONLY ☐ FINANCIAL ONLY

☐ Please check here if you authorize University Urology, PC to release info to any immediate family member.

☐ Please check here if you **DO NOT** authorize University Urology, PC to release information to anyone.

PLEASE MARK AN OPTION BELOW

Main Phone Number: _____

☐ Okay to leave message

☐ Do Not leave message (does not apply to call reminders)

Alternate Phone Number:_____

☐ Okay to leave message

☐ Do Not leave message (does not apply to call reminders)

This authorization will remain in effect until you give University Urology, PC a written document stating otherwise.

_____ _____

Patient Signature Date

_____ _____

Printed Name Date of Birth

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University Urology, PC

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name:_____ Date of Birth_____/_____/_____

I authorize the release of my information to:
University Urology, PC
1928 Alcoa Hwy
B-222
Knoxville, TN 37920
Phone number: 865-305-9254
Fax number: 865-305-4589

I know I have a right to revoke this authorization at any time. I know that if I revoke it, I must do it in writing, sign it and give it to University Urology at the above address. I know that my revocation will not apply to information that has already been disclosed by this authorization.

This authorization will remain in effect until you give University Urology, PC a written document stating otherwise.

_____ _____
Patient Signature Date

ACKNOWLEGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been offered or received a copy of University Urology, PC Notice of Privacy Practices. This notice describes how University Urology, PC may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

_____ _____
Patient Signature Date

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University Urology Financial Policy

Thank you for choosing our practice for your care. We are dedicated to providing the best possible care and service to you and regard your complete understanding of our financial policies as an essential element of your care and treatment.

Insurance

Your insurance policy is a contract between you and your insurance company. It is your responsibility to know your own coverage.

We accept and will file claims for all insurances as a courtesy to our patients. This does not mean we participate with all plans. Insurance companies are continually adding new policies and sometimes limit which providers may be in-network. If you have any concerns regarding participation, we suggest you contact your insurer directly.

As we are specialists, some insurance companies require a referral from your primary care physician. It is your responsibility to know if a referral is required and to obtain it before your appointment.

ASSIGNMENT OF BENEFITS/AUTHORIZATION FOR MEDICARE/INSURANCE BILLING

I request that payment of authorized Medicare and/or other insurance company benefits be made on my behalf for any services furnished me by University Urology, PC, including physician services. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration and/or other insurance companies and their agents any information needed to determine these benefits, benefits for related services or required review of medical records.

_____	_____	_____
Printed Name	**Signature**	**Date**

Copayment

Copayments are an agreement between you and your insurance provider. **All copayments are due at the time of service.** If you are unable to pay your copayment you will be asked to reschedule your appointment.

Balances

For patients with financial needs, we may offer no-interest payment plans on outstanding balances. Please contact our billing office immediately upon receipt of your statement to avoid collection letters for non-payment.

Overpayments

While we strive to collect only the proper amounts due and promptly post payments received, there are times when overpayments occur. It is our policy to refund most overpayments within 30 days of receipt: If you have an upcoming appointment within 3 months, a refund will not be issued until that visit has been processed. Refunds under $5 will not be issued, unless by request.

Nonpayment

If your account is in bad debt status and you have made no attempt at payment, we may suspend services until your account is made current. **All accounts sent to collections for non-payment will be subject to additional fees which cover our cost to collect your debt.**

I have read and agree to abide by the financial policy of University Urology, PC.

_____	_____	_____
Printed Name	**Signature**	**Date**

Please sign and return at your visit. A signed copy of this agreement will be scanned into your chart. Copy supplied upon request.

***Please be aware there is a $20 fee for *returned* checks.**

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University Urology Cancellation / No Show Policy

We strive to give all our patients the best quality of care possible. When you schedule an appointment with one of our physicians, we reserve this time for you. It is essential that you are involved in your care, starting with your reserved appointment time. Our office policy requires at least a:

24-hour advanced notice of appointment cancellation or reschedule

or

48-hour advance notice of cancellation or reschedule of a procedure

Unless we receive adequate notice or you no show for an appointment, a charge will be made to your account in the amount of $25 (twenty-five) for an office visit and $150 (one hundred fifty) for a procedure. ***This fee is not covered by your insurance and is your responsibility.***

Please note that our after-hours answering service cannot reschedule appointments or accept cancellations. Our staff is available Monday through Friday from 8:00 am to 4:30 pm to address your scheduling needs.

By signing below, you acknowledge you have received the University Urology Cancellation / No Show Policy for procedures and office appointments.

Thank you,
University Urology, PC

_____	_____	_____
Printed Name	**Signature**	**Date**

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