



Urology Associates of South Texas
 110 E Savannah Ste C-101
 McAllen TX 78503

Del Villar Vitko De Juana
 Feigl Ruiz Asase

PATIENT REGISTRATION FORM

REFERRAL INFORMATION:

Source: Referral from Dr. _____ ER @ _____

Family Friend Phone book Ins.provider director By employee @ hosp or dr office works in hosp Drs directory Paper/magazine

Radio TV Health fair, seminar, screening nurse @ adult day care internet, web site other

PATIENT INFORMATION:

Date: _____ Chart #: _____ Advised to bring x-rays / Labs

Appt: _____ @ _____ Reason for visit: _____

First name: _____ Last name: _____ Sex: Male Female Home phone: _____

Date of birth: _____ SSN: _____ - _____ - _____ Single Married Sep Divorced Name of spouse: _____

Mailing address: _____ City: _____ State: _____ Zip: _____ Cell: _____

Alternate address: _____ City: _____ State: _____ Zip: _____ Phone: _____

Employer: _____ City: _____ Phone: _____ Occupation: _____

Emerg contact name: _____ City: _____ Relationship: _____ Phone: _____

INSURANCE INFORMATION: PPO Non-PPO HMO Contracted Non-contracted

Primary company name: _____ Policy or ID # _____ Group #: _____

Address: _____ Phone: _____ - _____ - _____ Phone: _____ - _____ - _____

Name of insured: _____ DOB: _____ SSN: _____ - _____ - _____ P.O.E. _____

Relationship: Pt Spouse Parent _____

Secondary company name: _____ Policy or ID # _____ Group #: _____

Phone: _____ - _____ - _____ Phone: _____ - _____ - _____ Address: _____

Name of insured: _____ DOB: _____ SSN: _____ - _____ - _____ P.O.E. _____

Relationship: Pt Spouse Parent _____

FINANCIAL RESPONSIBILITY: Same as above

First name: _____ Last name: _____ Relationship: _____ SSN: _____ - _____ - _____

Mailing Chart #: _____ City: _____ State: _____ Zip: _____ Phone: _____

Employer: _____ City: _____ Phone: _____ Occupation: _____

MEDICARE

We do accept Medicare Assignment. The patient is responsible for payment of their \$110 annual deductible as well as the 20% of the Medicare allowable.

We do not file secondary insurance. However, in the event the secondary insurance is a crossover within the Medicare system, we will take a copy of the card and wait for direct payment from the secondary insurance.

PRIVATE PAYS

Our doctors and staff are very concerned about the cost of your healthcare. In light of this, we would like to address some current issues related to the cost of medical service in this office. What follows is a statement of our financial policy.

Considerable care has been taken in setting our fees. We want to assure you that the charges accurately reflect the complexity of care rendered and the skill and expertise required for your care. Our policy requires payment at the time of service for office visits and all services provided in the office unless other arrangements have been made in advance with our business office. For your convenience, we do accept **CASH, CHECKS, MASTERCARD/VISA, AMERICAN EXPRESS OR DISCOVER.**

INSURANCE

We will file your insurance claims only when surgical services are provided. However, you will be responsible for the co-insurance and the annual deductible, both of which require payment PRIOR to the surgery.

If an insurance company indicated that a physician's fees are above the "usual and customary," please understand that most physicians' fees are above the rate which insurance companies CHOOSE to pay. Their rate is most often lower than the current fees normally charged by any physician. We cannot and do not allow insurance companies to set the amount that we charge for services. Our agreement is with YOU and NOT your insurance company. You have chosen your insurance coverage. Although we will assist you in submitting your claim to your carrier, you are ultimately responsible for the services you receive. Payment to our office is YOUR responsibility and is neither contingent nor dependent upon your insurance carrier.

MANAGED CARE CONTRACTS

If you are a member of a PPO, EPO OR HMO'S in which we participate, your deductible and co-payment are required at the time of service. You are responsible for providing the correct billing information and/or any necessary forms, which we will need to file your claim to your carrier. You are also responsible to see that we have a current referral on hand if your insurance carrier requires one.

Insurance authorization and assignment of benefits

I request that payment of Medicare and /or other insurance company benefits be made directly to Urology Associates of South Texas, P.A. for any services furnished to me.

Medicare Life-Time Authorization

I request that payment under the medical insurance program be made directly to UAST and R.O.C. on any bills for services furnished me and I authorize the above named provider to release to the Social Security Administration, or its intermediaries or insurance carriers, any information needed for this claim or any related Medicare claim. I further permit a copy of this authorization to be used in its place of the original

Authorization to release Medical Information

I authorize the release of any medical information about me for this or a related Medicare/Other insurance claim to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier. I permit a copy of this authorization to be used in place of the original. I understand that it is mandatory to notify Urology Associates of South Texas of any other party who may be responsible for paying for my treatment.

HIPAA Statement (Health Insurance Portability and Accountability Act of 1996)

Your medical records and parts thereof may be given to other parties such as billing staff, insurance, transcription, Health and Human Services and organizations that request specific information, or they need the records to process information given to them by Urology Associates of South Texas. Urology Associates will only give this information on a "as needed" basis and strict confidentiality will be adhered to.

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Patient Signature

Date