Urology Associates of South Texas, PA

Physician to see: ☐Del Villar ☐De Juana ☐Ruiz ☐Vitko ☐Feigl ☐Harrison

Patient Registration Form

Patient Information: ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐ Dr.

e-mail address:______________________________

First M.I. Last

Address City State Zip

Home Phone Work Phone S.S. #

Birthdate Age Sex: ☐M or ☐ F Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed Name of Spouse:

Employer Occupation

Employer's Address City State Zip

Financial Responsibility (If other than patient)

First M.I. Last

Address City State Zip

Home Phone Work Phone S.S. #

Employer Occupation

Address City

Insurance Information (Please present your card to the receptionist)

Primary Insurance Company Phone #:

Address City State Zip

Insured's Name I.D. #: Group #: Date of Birth:

Secondary Insurance Company Phone #:

Employer's Address City State Zip

Insured's Name I.D. #: Group #: Date of Birth:

Additional Information

Emergency Contact #1:

Name Address City State Zip Ph. #:

Emergency Contact #2:

Name Address City State Zip Ph. #:

If you are a Winter Texan, please indicate your permanent address:

Medical Information

Medical Complaint or Reason for visit: ______________________________

Referring Physician:

Have X-rays been taken? ☐ Yes ☐ No

How did you hear about us? ☐Health Fair ☐Tv ☐Radio ☐Yellow Pages ☐Newspaper Ad ☐Hospital Referral Service

☐Physician ☐Friend ☐Relative: ☐Other:______________________________

Signature of Patient or Legal Guardian: ______________________________Date:____________________

MEDICARE
We do accept Medicare Assignment. The patient is responsible for payment of their $100 annual deductible as well as the 20% of the Medicare allowable.

We do not file secondary insurance. However, if the patient's 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 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 do file primary 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 hysician's 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.

PREFERRED PROVIDER MEMBERS (PPO)
If you are a member of a PPO 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 authorized Medicare/other insurance company benefits be made either to me or on my behalf to Urology Associates of South Texas for any services furnished to me.

Medicare Life-Time Authorization
I request that payment under the medical insurance program be made either to me or the provider named above on any bills for services furnished me and I authorize the above named provider to release to the the Social Security Administration, or its intermediaries or 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 adhrered 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