CASCADES UROLOGY CENTER, INC.

REGISTRATION FORM

PATIENT'S FULL NAME _____

AGE: _____ DATE OF BIRTH: _____ **SOCIAL SECURITY #** _____

MALE (___) FEMALE (___) MARITAL STATUS: SINGLE (___) MARRIED (___) DIVORCED (___) WIDOWED (___)

ADDRESS: _____ HOME **PHONE** (_____) _____

CITY: _____ STATE: _____ ZIP **CODE**: _____ CELL **PHONE** (_____) _____

PATIENT'S **EMPLOYER** _____ **PHONE #** (_____) _____

SPOUSE OR BOTH PARENTS' NAMES (IF A CHILD) _____

SPOUSE/PARENT **EMPLOYER** _____ **PHONE #** (_____) _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

GUARDIAN (RESPONSIBLE FOR THE BILL) _____ **HOME PHONE** (_____) _____

ADDRESS: _____ CITY: _____ ZIP: _____ **WORK PHONE** (_____) _____

IN THE EVENT OF EMERGENCY :(SOMEONE OTHER THAN YOUR SPOUSE OR PARENT)

CONTACT_____RELATIONSHIP_____HOME PHONE_____WORK PHONE_____

INSURANCE INFORMATION

PRIMARY INSURANCE

NAME_____ **POLICY #**_____ **GROUP#**_____

ADDRESS_____ POLICY HOLDER'S NAME_____

CITY_____STATE_____ZIP_____ DATE OF BIRTH_____

SECONDARY INSURANCE

NAME_____ **POLICY #**_____ **GROUP#**_____

ADDRESS_____ POLICY HOLDER'S NAME_____

CITY_____STATE_____ZIP_____ DATE OF BIRTH_____

FAMILY PHYSICIAN_____

REFERRING PHYSICIAN_____

PHARMACY NAME_____ PHONE # (_____) _____

HIPAA

(PLEASE INITIAL)_____I ACKNOWLEDGE RECEIPT OF "NOTICE OF PRIVACY PRACTICES" _____DATE

PLEASE TURN THE PAGE

RELEASE OF INFORMATION: PATIENT'S NAME _____

I hereby authorize that CASCADES UROLOGY CENTER, INC. can provide a report of my diagnosis, treatment, prognosis & recommendations, as well as other data pertinent to my treatment to my doctor_____

I hereby authorize any physician, hospital or medical care facility to provide all information on my medical history and treatment to CASCADES UROLOGY CENTER, INC. and I understand that photocopies of this form are to be held as valid as the original.

PATIENT OR GUARDIAN SIGNATURE_____ 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. Payment 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 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 hereby authorize the physicians of CASCADES UROLOGY CENTER, INC. to release information requested by my insurance company, any hospital or physician as needed. I hereby authorize assignment and payment directly to CASCADES UROLOGY CENTER, INC. for services rendered. I understand that I am responsible for any balance or charges that exceed or are not covered by my insurance carrier.

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 CASCADES UROLOGY CENTER, INC. for any services furnished me by CASCADES UROLOGY CENTER, INC. I authorize any holder of medical information about me to release to the Health Care Financing Administration 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 Medicare assigned cases, the physician agrees to accept the charge determination of the Medicare 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 THE PATIENT_____ DATE_____