# PATIENT REGISTRATION

DOCTOR ______________________ DATE ______________________

ACCOUNT # ______________________

## PATIENT INFORMATION

First Name ______________ Middle Name ______________ Last Name ______________

Patient Address ______________ City ______________ State ______ Zip ______

Home Phone# ( ) ______ Cell Phone ( ) ______ Soc. Sec. No. ______ Gender ☐ Male ☐ Female Birthdate / /

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated Employer ______________ Employer's Phone # ______

## RESPONSIBLE PARTY

IF PATIENT IS NOT RESPONSIBLE FOR THE BILL, PLEASE INDICATE WHO IS RESPONSIBLE

First Name ______________ Middle Name ______________ Last Name ______________

Responsible Party Address ______________ City ______________ State ______ Zip ______

Phone # ( ) ______ Soc. Sec. No. ______ Relationship ______ DOB ______

## PATIENT CONTACT INFORMATION

Urology Centers of Alabama, PC and its staff has my permission to discuss my account or medical conditions which may include symptoms, treatments, tests, medicine or other protected health information with the following persons to facilitate my treatment and payment of my account.

Name ______________ Relationship ______________ Phone ______________

Name ______________ Relationship ______________ Phone ______________

Name ______________ Relationship ______________ Phone ______________

I understand authorizing the relase of this information is voluntary and does not affect my access to treatment. I can refuse to make this authorization. I understand this authorization will remain in effect until I revoke it by completing a new form. I understand if this information is shared with these individuals above, that they may disclose my protected health information to other individuals. I have indicated my agreement with this authorization by signing below.

## REFERRAL INFORMATION

Referred by ______________ Phone Number ______________

This is my Doctor ☐ or a Relative ☐ or a Friend ☐

## INSURANCE INFORMATION

Name of Insurance Company ______________ Group Policy # ______________ ID # ______________

Insured Name ______________ Address City, State, Zip ______________

Phone # ( ) ______ Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other Birthdate ______ Gender ☐ Male ☐ Female

Employer ______________ Insured Social Security # ______________ Effective Date of Insurance ______________

Does Your Insurance Require A Referral? Yes ☐ No ☐ Do You Have A Waiting Period? Yes ☐ No ☐ How Much is Your Co-Pay? ______

Blue Cross of Alabama Contract # ______________ Is This PMD: Yes ☐ No ☐

Medicare Contract # ______________ Do You Have Part B? Yes ☐ No ☐

Medicaid Contract # ______________

Other Insurance:

Name ______________ Contract # ______________ Group # ______________

Employer ______________ Insured Social Security # ______________ Effective Date of Insurance ______________

**Which Insurance is Primary?** ______________

I accept full responsibility for all charges for services rendered by Urology Centers of Alabama, PC. I agree to pay all costs of collection, including reasonable attorney fees. I authorize the release of any medical information necessary for the completion of Insurance claim forms. I assign all benefits under my current health insurance policies and authorize payment directly to Urology Centers of Alabama, PC of any medical or government benefits due from my insurance and/or government program. I understand my insurance may not pay all of my charges and I agree to promptly pay the difference or the entire bill. I have received a copy of the Notice of Privacy Practices statement. I have authorized Urology Centers of Alabama, PC to discuss my protected health information with the above named individuals. I have read all of the information on the reverse side of this form and I agree to these policies.

______________________________
Patient's or Authorized Representative's Signature Date

**INSURANCE IS FILED AS A COURTESY - PAYMENT IS EXPECTED AT TIME OF SERVICE - THANK YOU**