

UROLOGY P.C. & UROLOGY SURGICAL CENTER – Patient Registration					
Referring Physician:					Today's Date
Primary Care Physician: Address:					
PATIENT INFORMATION					
Patient's LEGAL Name					
Last Name:	First:	M.I.	Birth Date:	Birth Sex:	
			<input type="checkbox"/> Male <input type="checkbox"/> Female		
Nickname:		Former/Maiden name(s):			
Relationship Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Separated			SSN:		
Street Address:			Billing Address (if different):		
City	State	Zip Code	Land Line: (     )		<input type="checkbox"/> Primary
			Cell Phone: (     )		<input type="checkbox"/> Primary
Email address:					
Current Work Status: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Retired <input type="checkbox"/> Disabled <input type="checkbox"/> Not Employed <input type="checkbox"/> College Student					
Occupation:	Employer Name		Address:		Work Phone & Ext.:
<b>PRIMARY CONTACT PERSON (SPOUSE, PARENT, SIGNIFICANT OTHER, ETC.)</b>					
Name:			Relationship:		
Address:				Employer:	
Home Phone: (     )		Work Phone: (     )		Cell Phone: (     )	
<b>SECONDARY CONTACT PERSON (PARENT, CHILD, NEXT OF KIN, ETC.)</b>					
Name:			Relationship:		
Address:				Employer:	
Home Phone: (     )		Work Phone: (     )		Cell Phone: (     )	
<b>GUARDIANSHIP</b>					
Does someone have <b>court appointed guardianship</b> for patient? (bring paperwork) <input type="checkbox"/> Yes <input type="checkbox"/> No			Guardian Name:		Phone:
Is this patient a Ward of the State? <input type="checkbox"/> Yes <input type="checkbox"/> No			Case Manager:		Phone:
<b>INSURANCE COVERAGE</b>					
Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No <b>If yes, please complete appropriate insurance information below.</b>					
<b>MEDICARE COVERAGE (specify)</b>			<b>MEDICAID (WELFARE) COVERAGE</b>		
Is Medicare Primary? <input type="checkbox"/> Yes <input type="checkbox"/> No			Is this patient covered by Medicaid? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Medicare #			NE Total Care #		
Railroad Medicare #			Healthy Blue #		
Medicare (Hospital Only) #			UHC Community Plan #		
Medicare Advantage Plan (Blue Advantage, Aetna Premier, etc.)			<b>HOME HEALTH CARE</b>		
Plan Name:			<input type="checkbox"/> Yes <input type="checkbox"/> No		
Plan #	Group #		If Yes, list Provider:		
<b>SUPPLEMENTAL or OTHER INSURANCE COVERAGE</b>					
Insurance Company & Address:				Primary Insurance:	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
Subscriber's Name		Subscriber's SSN		Subscriber's Date of Birth	
				Is this a Self/Individual Plan?	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
Member ID		Group #	Subscriber's Relationship to Patient		Subscriber's Employer
<b>SUPPLEMENTAL or OTHER INSURANCE COVERAGE</b>					
Insurance Company & Address:				Primary Insurance:	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
Subscriber's Name		Subscriber's SSN		Subscriber's Date of Birth	
				Is this a Self/Individual Plan?	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
Member ID		Group #	Subscriber's Relationship to Patient		Subscriber's Employer

What is your preferred pharmacy? \_\_\_\_\_ Location \_\_\_\_\_

Race/Ethnicity (circle one): **White** **Hispanic/Latino** **Black/African American** **Asian** **Multi-Racial** **Decline to specify**


Preferred Language (circle one): **English** **Other** \_\_\_\_\_  Interpreter Required

Do you have a Medical Power of Attorney (please provide documentation)? **YES** **NO**

**If yes**, please indicate name, address & phone: \_\_\_\_\_  
\_\_\_\_\_

Is this urology medical condition due to an accident of any kind? **YES** **NO**

If yes, was it (choose one): **Work Related** **Auto** **Home** **Other**

<b>MEDICARE</b> <b>PATIENTS ONLY</b> 	1. Has the VA authorized and agreed to pay for your visit today?	<b>YES</b>	<b>NO</b>
	2. Are you receiving benefits from a government research grant?	<b>YES</b>	<b>NO</b>
	3. Do you have a Federal Black Lung Card?	<b>YES</b>	<b>NO</b>
	4. Are you covered by a current employer's health insurance plan through you or your spouse's employer?	<b>YES</b>	<b>NO</b>
	5. Are you entitled to Medicare because of disability or End Stage Renal Disease?	<b>YES</b>	<b>NO</b>
*If patient marks yes to any of the above 5 questions or accident-related question above, complete full MSPQ.			

→ **AUTHORIZATION TO TREAT**

I authorize and direct my physician and his/her designee to provide medical services and diagnostic services for me as they deem necessary and appropriate including but not limited to services involving pathology and radiology. I understand that I have the right to receive information, to ask questions and to receive answers to my questions about my treatment plan. I also have the right to refuse treatment and to seek a second opinion.

→ **ASSIGNMENT OF BENEFITS**

I hereby assign all medical and/or surgical insurance benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance and any other health plans to the physician caring for me. I understand that I am financially responsible for all allowed charges or co-insurance amounts which are not paid by my insurance company in full within 30 days of the first statement received. I understand that not all services are a covered benefit in all insurance plans and that my insurance coverage is an agreement between me and my insurance company. Should I elect to proceed with a non-covered benefit service, I understand I am financially responsible. We offer monthly auto debit payment plans based on account balance and low interest bank loans upon request. We do use outside agencies as a means of collections should we deem it necessary.

→ **ADVANCE DIRECTIVES**

You have the right to have an advance directive, such as a living will or health care proxy. However, due to CMS regulations, our clinic and surgical center will suspend Advance Directives at our facilities. In the event of an emergency, we will attempt to stabilize you and transfer you to an acute care facility for evaluation and treatment as appropriate.

→ **RELEASE OF INFORMATION TO INSURANCE COMPANY**

I authorize Urology, PC and/or Urology Surgical Center to release to the Medicare carrier and/or the Insurance Carrier listed above, any information needed for this or a related claim. I permit a copy of this authorization to be used in place of the original and request payment of this claim be made directly to Urology, PC or Urology Surgical Center.

→ **NEBRASKA STATE LAW REGARDING MINORS** - Nebraska state law defines a minor as anyone 18 years of age and younger. These patients are required by this law to have a legal guardian present or if this is not possible, you must make prior arrangements with our office. If prior arrangements are not made, it could result in the appointment needing to be rescheduled.

→ I understand there will be a \$25 fee for a no show appointment or returned check (See also Financial Policy) payable only by cash, money order, credit or debit card.

→ I understand the Patient Rights and Responsibilities are listed on Urology, P.C.'s website at [www.lincolnurologypc.com](http://www.lincolnurologypc.com) and I may request a copy at any time. I hereby consent to receive calls, texts and emails from Urology, P.C. or any business associates Urology, P.C. has contracted with at the phone number(s) and email addresses provided or associated with my account. I understand that methods of contact may include pre-recorded or artificial message and/or use of an automated dialing system.

**I understand that I will be responsible for all charges if the listed insurance information is not correct.**

Signature \_\_\_\_\_ Date \_\_\_\_\_