Urologic Surgeons, Inc. Patient Information/Registration Form (Please Print)

Date:_____ Sex:_____ Age:_____ Social Security #:_____

Name:_____
(Last) (First) (M.I.)

Home Address: (**No PO Boxes**):_____Apartment #:_____

City:_____State:_____Zip:_____

Date of Birth:_____ Marital Status: _____

Home Phone:_____ Work Phone:_____

Cell Phone: _____ Pharmacy phone number: _____

Is there any ongoing litigation concerning your medical condition? (circle) Yes No

Where do you have lab tests done? _____Quest _____LabCorp _____Other:_____

Is this a Worker's Compensation case? (circle) Yes No

Primary Doctor's name and phone number: _____

How did you hear about Dr. Garber?_____

We will be glad to help you obtain the appropriate reimbursement from your insurance carrier(s), and will bill your carrier(s) for covered office visits and surgical procedures. It is **your** responsibility to obtain any necessary **electronic referrals** from your primary doctor, if required by your insurance policy. If you have not obtained a valid referral, we may reschedule your appointment. Co-pays (cash, check, or credit card) are due at the time of your office visit. Not all services are covered by health insurance plans. You are responsible for any deductibles, co-payments, co-insurance, or charges for non-covered services according to the terms of your insurance contracts. **You must supply us with ALL of your current insurance cards (primary and secondary)**, and must notify our office promptly if your address or insurance coverage changes in any way. Failure to do so may result in incorrect billing, denial of reimbursement from your new carrier(s), and additional personal charges. If your account is referred for collection, you will be responsible for collection costs, court costs, and reasonable attorney's fees. Patient without insurance coverage are requested to pay for services and supplies when rendered. **We do not participate with any Medicaid or Medicaid HMO insurance plans.**

By signing this form, you authorize payment from your insurance carrier(s) for any services or supplies rendered, to be directed to Urologic Surgeons, Inc./Bruce B. Garber, MD. You also authorize the release of your Protected Health Information (medical records) in order to process your insurance claims, and to a third-party benefits verification service. Additionally, you acknowledge receipt of a copy of our *HIPAA Notice of Privacy Practices*. Please give our office at least 24 hours notice if you are unable to keep an appointment. There is a charge for copying and mailing your medical records, and for completing any forms. We would like to take this opportunity to welcome you to our practice. We are committed to providing you with the best possible Urologic health care.

X_____
(Signature) 033117