

PATIENT REGISTRATION

PATIENT NAME _____ SOCIAL SECURITY # _____

DATE OF BIRTH _____ Age _____ MALE ___ FEMALE ___

PATIENT ADDRESS _____

CITY _____ STATE _____ ZIPCODE _____

HOME PHONE # _____ BUSINESS PHONE # _____

CELL PHONE # _____ EMAIL ADDRESS _____

EMPLOYER _____ EMPLOYER ADDRESS _____

SPOUSE/PARENT NAME _____ DATE OF BIRTH _____ SS# _____

SPOUSE/PARENT EMPLOYER _____

EMERGENY CONTACT NAME _____ PHONE# _____

FAMILY PHYSICIAN _____

CONCERNING FINANCIAL ARRANGEMENTS

. IF YOU HAVE MEDICAL INSURANCE WE WANT TO HELP YOU RECEIVE YOUR ALLOWABLE BENEFITS.**SOME INSURANCE MAY NOT BE FULLY COMPATIBLE WITH REIMBURSEMENT FOR SERVICES PROVIDED BY EAST TENNESSEE UROLOGIC ASSOCIATES. PLEASE CONTACT YOUR INSURANCE CARRIER TO VERIFY BENEFIT AND ELIGIBILITY FOR SERVICES PROVIDED HERE.**

WE REQUEST PAYMENT AT THE TIME SERVICE IS RENDERED, UNLESS ARRANGEMENTS HAVE BEEN MADE IN ADVANCE. YOU MAY PAY CASH, CHECK, MASTER CARD, VISA AND DISCOVER. WE REALIZE CERTAIN UNFORESEEN FINANCIAL PROBLEMS MAY AFFECT TIMELY PAYMENT OF YOUR ACCOUNT. IF SUCH PROBLEMS ARISE, PLEASE CONTACT US FOR ASSISTANCE IN THE MANAGEMENT OF YOUR ACCOUNT.

I UNDERSTAND AND AGREE THAT I AM ULTIMATELY RESPONSIBLE FOR PAYMENT OF MY ACCOUNT AND AGREE TO THE TERMS ABOVE. I WILL NOTIFY YOU OF ANY CHANGES IN THE ABOVE INFORMATION.

SIGNATURE

DATE

**CO PAY EXPECTED DATE OF SERVICE
IF INSURANCE REFERRAL IS REQUIRED, YOU ARE RESPONSIBLE FOR
OBTAINING REFERRAL PRIOR TO BEING SEEN BY THE DOCTOR.**

PLEASE HAVE INSURANCE CARDS AVAILABLE TO BE COPIED.

PLEASE SIGN THIS AUTHORIZATION AND LIST PRIMARY AND SECONDARY
INSURANCE COMPANIES.

I _____ AUTHORIZE THE RELEASE OF ANY
MEDICAL INFORMATION NECESSARY TO PROCESS MY CLAIM AND REQUEST
PAYMENT OF BENEFITS EITHER TO MYSELF OR TO THE PARTY WHO ACCEPTS
ASSIGNMENT.

PRIMARY INSURANCE _____

SECONDARY INSURANCE _____

PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

Our office is fully committed to compliance with HIPPA guidelines by:

1. Providing appropriate **security** for our patient records
2. Protecting the **privacy** of our patient's medical information
3. Providing our patients with proper **access** to their medical records
4. Appropriately maintaining our patient information and billing processes in compliance with **National standards**

**You have the right to review our privacy notice, to request restrictions and revoke
consent to our privacy notice.**

**You have the right to confidential communication, may we call and leave a message
on you home phone _____**

List anyone else authorized to obtain your information

Name _____ phone _____

Name _____ phone _____

PRINT YOUR NAME

YOUR SIGNATURE