Arizona Center for Vasectomy and Urology
PATIENT REGISTRATION

Welcome to our office. We are committed to providing the best, most comprehensive care possible. We encourage you to ask questions. Please assist us by providing the following information.

Please Print. **All information is confidential and is released only with your consent.** **Today's Date:**

Patient Name
Last: First: MI: Nickname:

Sex: Male Female Date of Birth: Age:

Status: Single Married Widowed Divorced Separated

Parent or Legal Guardian if Patient is a Minor:

Patient's Social Security Number Driver's License No./State

Home Address City State Zip

Mailing Address if Different City State Zip

Please indicate phone number and order of call preference (1st, 2nd, 3rd)

( ) Home Ph # : ( ) Work Ph # : ( ) Cell Ph # :

Employer's Name Occupation

Employer's Address City State Zip

Spouse Name Employer

Primary Care Physician: How were you referred to our practice?

Notify in Case of Emergency:

Name Relationship Home Ph # Work Ph #

Address City State Zip

Nearest Relative (not living with you) Relationship Home Ph # Work Ph #

Insurance Information: (All information requested MUST be furnished in order for carrier to be billed)

Primary Insurance Company Claim Address/City/State/Zip/Ph#

Insurance ID No.: Group#: Effective Date:

Subscriber's Name Date of Birth SSN# Relation to Patient:

Secondary Insurance Company Claim Address/City/State/Zip/Ph #

Insurance ID No.: Group#: Effective Date:

Subscriber's Name Date of Birth SSN# Relation to Patient

Signature of Person Filling out Form Relation to Patient Printed Name Date

ARIZONA CENTER FOR VASECTOMY AND UROLOGY. P.C.
FINANCIAL POLICY

Patient Name: ____ Date of Birth: ________________________

______ **BASIC POLICY** Payment in full is due at the time service is provided unless prior arrangements have been made. Co-payments are due at the time of service. If you are unprepared to pay your co-pay on the day of your visit a $5.00 service fee will be charged to your account.

______ **FOR PATIENTS WITH INSURANCE:** We bill most insurance carriers for you if proper paperwork is provided to us. We will also bill most secondary insurance companies for you. If your insurance requires a referral or prior authorization it is your responsibility to assure that one is available to our office prior to or at the time of your service. Our office contracts with many insurance carriers, please contact your insurance prior to your appointment to verify you are receiving care from a participating provider. Co-payments, coinsurance and deductibles are due at the time of service. Since your agreement with your insurance carrier is a private contract between you and your carrier, we do not routinely research why an insurance carrier has not paid or why it paid less than anticipated for care. If you have questions about your benefits or your insurance carrier's decision to pay or deny your claim, please contact your insurance carrier directly. If an insurance carrier has not paid within 60 days of billing, professional fees are due and payable in full from you.

______ **MEDICARE PATIENTS:** We will bill Medicare for you. We will also bill secondary insurance carriers for you. All coinsurance amounts or deductibles not covered by an insurance plan are due and payable at the time service is rendered.

______ **MEDICAID PATIENTS:** We do not accept Medicaid at this time. You are responsible for payment at the time of service.

______ **SURGERY FEES:** All copays, deductibles, and payments for non-covered surgical procedures are due prior to your surgery. Prior authorization may be required by your carrier.

______ **NONCOVERED SERVICES:** It is your responsibility, as the insured member, to know what your insurance policy covers. Any care not paid for by your existing insurance coverage will require payment in full at the time services are provided or upon notice of insurance claim denial.

______ **MISSED APPOINTMENTS:** In fairness to other patients and to the doctor, we require at least 24 hours notice to cancel appointments. You may be charged a $25.00 fee for missed appointments.

COLLECTION OF FEES: If it becomes necessary to bill you more than once for your share of services, a $5.00 per month fee will charged to your account until payment in full has been received.

______ In the event action is brought hereof, the prevailing party shall be entitled to recover from the other party the court costs and attorney fees as determined and awarded by the court. If this is referred for collection, I/We agree to pay collection fees up to 50% on the balance owing. If legal action is deemed necessary, I/we agree to pay reasonable attorney's fees and court costs in addition to the above costs.

MEDICARE PATIENTS: SIGNATURE ON FILE I request payment of authorized Medicare benefits be made to Arizona Center for Vasectomy and Urology, P. C. for any services furnished to me by the listed provider/supplier. I authorize any holder of medical information about me to release to the Medicare Program and its agents any information needed to determine these benefits or the benefits payable to related services.

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Signature Printed Name Date

ASSIGNMENT OF INSURANCE BENEFITS: Patients with insurance please read and sign below. I hereby assign all medical and/or surgical benefits for any services furnished to me to Arizona Center for Vasectomy and Urology, P.C. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

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Signature Printed Name Date

I have read, understand, and agree to the above financial policy for payment of professional fees.
The patient is ultimately responsible for payment of all professional fees.

____________________________________ ____________________________________
Signature Printed Name Date Witness Date