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 Liberty, MO 64068  
 816-781-8400  
 816-781-8263 (fax)



UROLOGY  
 SPECIALISTS, P.C.

2700 Clay Edwards Dr.  
 Suite 300  
 North Kansas City, MO 64116  
 816-842-0171  
 816-842-3582 (fax)

## REGISTRATION FORM

(Please Print)

Today's date:

PATIENT INFORMATION										
Patient's last name:			First:		Middle:		<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?		Patient Social Security #:			Birth date: / /		Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	
Street address:				Home phone no.: ( )			Cell phone no.: ( )			
P.O. Box:		City:			State:		ZIP Code:			
Occupation:		Employer:				Employer phone no.: ( )				
Chose clinic because/Referred to clinic by (please check one box):				<input type="checkbox"/> Dr.			<input type="checkbox"/> Insurance Plan		<input type="checkbox"/> Hospital	
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Close to home/work	<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> Internet	<input type="checkbox"/> Other					
Responsible Party (If patient is a minor):										
Home Phone No.:			Cell Phone No.:							
INSURANCE INFORMATION										
Is this patient covered by insurance?		<input type="checkbox"/> Yes			<input type="checkbox"/> No					
Name of Primary Insurance:										
Insured's Name:		Member ID#:		Group #:			Birth Date of Insured:			
Employer:		Employer address:				Employer phone no.: ( )				
Patient's relationship to insured:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other					
Name of Secondary Insurance:										
Insured's Name:		Member ID#:		Group #:			Birth Date of Insured:			
Employer:		Employer address:				Employer phone no.: ( )				
Patient's relationship to insured:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other					
IN CASE OF EMERGENCY										
Name of local friend or relative:				Home phone no.: ( )		Cell phone no.: ( )		Work phone no.: ( )		
Relationship to Patient:										

Patient Name:

Patient Date of Birth:

**PATIENT INFORMATION**

Name of **primary care physician**: \_\_\_\_\_ Phone No.: \_\_\_\_\_

Street address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP Code: \_\_\_\_\_

Name of **physician who ordered consultation** (if different): \_\_\_\_\_ Phone No.: \_\_\_\_\_

Street address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP Code: \_\_\_\_\_

**COMMERCIAL INSURANCE ASSIGNMENT & RELEASE**

I, the undersigned, have insurance coverage with \_\_\_\_\_  
Name of Insurance Company  
And assign directly to *UROLOGY SPECIALISTS, P.C.*, all medical benefits, if any, otherwise payable to me for services rendered. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.  
\_\_\_\_\_  
*Signature of Insured/Guardian* \_\_\_\_\_ *Date* \_\_\_\_\_

**MEDIGAP INSURANCE AUTHORIZATION**

I hereby authorize payment of my Medigap benefits to *UROLOGY SPECIALISTS, P.C.* for all claims filed on my behalf. This authorization applies to all services until it is revoked by me or my representative.  
Beneficiary Signature: \_\_\_\_\_ Medicare # \_\_\_\_\_  
Medigap Insurance Name: \_\_\_\_\_ Date: \_\_\_\_\_

**MEDICARE AUTHORIZATION**

I request that payment of authorized Medicare benefits be made either to me or on my behalf to *UROLOGY SPECIALISTS, P.C.*, for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.  
\_\_\_\_\_  
*Signature of Beneficiary* \_\_\_\_\_ *Date* \_\_\_\_\_

**PATIENT FINANCIAL AGREEMENT**

I, the undersigned, agree to be responsible for the balance of my account. Although an insurance claim (if applicable) will be filed with my insurance company by the doctor on my behalf, negotiating payments through my insurance company ultimately is my obligation. If my insurance requires a referral/authorization from my Primary Care Physician, I understand it is my responsibility to obtain this. If I have no insurance, I understand that payment will be made at the time of services are rendered unless financial arrangements have been made PRIOR to the services. A statement will be mailed to me each month showing the total balance due from me and will be considered past due within 30 days from receipt. Items billed to my insurance will become past due if no reply is received within 45 days. If I am unable to make payment in full, I understand that I should call the billing department immediately to make payment arrangements. I understand that if no payment has been received or financial arrangements made on my balance after 45 days, my account may be referred for collections. If my account is referred for collections, I understand that I will be responsible for the balance as well as all collection costs and reasonable attorney's fees.  
\_\_\_\_\_  
*Signature of Responsible Party* \_\_\_\_\_ *Date* \_\_\_\_\_