ARIZONA UROLOGY

PATIENT REGISTRATION FORM

CURRENT PATIENT INFORMATION -- PLEASE PRINT

Patient Name: _____

Address: _____

City:_____State:_____Zip: _____

Home Phone: ( )_____- _____

Cell Phone: ( )_____- _____

Sex (please circle): Male/Female

Date of Birth: _____

Social Security No.: _____

Patient email:_____

Patient Referred by: _____

Primary Care Provider: _____

EMERGENCY CONTACT INFORMATION

Name: _____

Relationship to patient: _____

Phone: ( )_____- _____

EMPLOYMENT INFORMATION

Employment (please circle): Full Time / Not Employed / Retired

Employer: _____

Address: _____

Phone: ( )_____- _____

REQUIRED BY GOVERNMENT MANDATE (you may refuse)

Language (please circle): English / Spanish / Other: _____

Race (please circle): White / Asian / Native American / African American / Native Hawaiian or Other Pacific Islander / Declined

Ethnicity (please circle): Hispanic or Latino / Non Hispanic or Latino / Declined

Marital Status (please circle): Married / Single / Divorced

PHARMACY INFORMATION

Name:_____

Crossroads:_____

Phone: ( )_____- _____

MAIL ORDER PHARMACY

Name:_____

Address: _____

Phone: ( )_____- _____

PRIMARY INSURANCE INFORMATION

Insurance Plan Name: _____

ID Number: _____

Group Number: _____

Policy Holder Name: _____

Date of Birth: _____ Sex (please circle): **M** or **F**

Patient's relationship to policy holder:_____

SECONDARY INSURANCE INFORMATION

Insurance Plan Name: _____

ID Number: _____

Group Number: _____

Policy Holder Name: _____

Date of Birth: _____ Sex (please circle): **M** or **F**

Patient's relationship to policy holder:_____

RELEASE OF INFORMATION

I,_____hereby authorize Palo Verde Hematology Oncology, DBA Arizona Urology to release or discuss any and all information pertaining to myself or my medical records with the following people.

Name: _____ Relationship: _____ Phone: ( )_____- _____

Name: _____ Relationship: _____ Phone: ( )_____- _____

Name: _____ Relationship: _____ Phone: ( )_____- _____

I authorize Arizona Urology to contact me at (please circle): Home Phone / Work Phone / Mobile Phone / Portal / Email

To the best of my knowledge the above information is complete and accurate.

Signed _____ **Date** _____

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** Please sign and date each item below**

ACKNOWLEDGEMENT AND AUTHORIZATION:

- **I have read and understand the HIPAA/Privacy Policy for Palo Verde Hematology oncology, DBA Arizona Urology**

Signed_____**Date:**_____

- **I have read and understand the Financial Policy for Palo Verde Hematology oncology, DBA Arizona Urology**

Signed_____**Date:**_____

- **AUTHORIZATION TO BILL/PAY: I hereby authorize Palo Verde Hematology oncology, DBA Arizona Urology to release any information required in the course of my examination or treatment to my insurance(s). I also hereby authorize payment directly to Palo Verde Hematology oncology, DBA Arizona Urology for the surgical and/or medical benefits, if any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges not covered by my insurance. Further, I understand that I am responsible for all charges incurred in the collection of my account(s) for today's visit, and all future visits with Palo Verde Hematology oncology, DBA Arizona Urology, and will pay all fees involved should my account(s) be placed with a collection service. Finance charges will begin to accrue on any unpaid patient responsibility balance after 90 days old.**

Signed_____**Date:**_____

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A. Notifier:

B. Patient Name: _____ **C. Identification Number: _____**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If your insurance doesn't pay for **D.** below, you may have to pay.

Your insurance does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect your insurance may not pay for the **D.** below.

(D) General Description Of Service:	*(E)* **Reason Your Insurance May Not Pay:**	*(F)* **Estimated Cost:**
New patient visit/consultation with a specialist **CPT: 99202-99205**	1. Considered as part of your Deductible or Co-insurance 2. Non-covered benefit 3. Non-covered diagnosis 4. Not deemed medically necessary 5. Denied as too frequent	Not to exceed $155

WHAT YOU NEED TO DO NOW:

• Read this notice, so you can make an informed decision about your care.
• Ask us any questions that you may have after you finish reading.
• Choose an option below about whether to receive the **D.** listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

(G)* OPTIONS:** ***Check only one box. **We cannot choose a box for you.**

D OPTION 1. I want the ***(D)***_Service_ listed above. You may ask to be paid now, but I also want my insurance billed for an official decision on payment, which is sent to me on a Explanation Of Benefits(EOB). I understand that if my insurance doesn't pay, I am responsible for payment, but **I can appeal to my insurance** by following the directions on the EOB**.** If my insurance does pay, you will refund any payments I made to you, less co-pays or deductibles.

D OPTION 2. I want the ***(D)***_Service__ listed above, but do not bill my insurance. You may ask to be paid now as I am responsible for payment. **I cannot appeal if my insurance is not billed**.

D OPTION 3. I don't want the ***(D)***_Service_ listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if my insurance would pay.**

H. Additional Information:

This notice gives our opinion, not an official Insurance Carrier decision. If you have other questions on this notice please contact your insurance carrier. Signing below means that you have received and understand this notice. You also receive a copy.

***(I)* Signature:**	***(J)* Date:**

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

Form CMS-R-131 (03/11) Form Approved OMB No. 0938-05

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HISTORY AND PHYSICAL FORM (PATIENT)

Patient: _____ **DOB:** _____

Referring Physician: _____ Marital Status: _____ Age: _____

Height: _____ Weight: _____

Reason For Visit: _____

Past Medical & Social History (Please fill out completely)

Allergic to (Include Medications):

_____

_____

Surgeries:

_____

_____

Medical Illness:

_____

_____

☐ Glaucoma ☐ Tendinitis

Medications (list dose and frequency):

Name	Frequency	Name	Frequency
☐ Coumadin	_____	☐ Aspirin	_____
☐ Heparin	_____	☐ Ibuprofen	_____
☐ Plavix	_____	☐ Lipitor	_____

Other (Please List):

Name	Frequency	Name	Frequency
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Do you have any medical condition that requires antibiotics prior to surgery? ☐ YES ☐ NO

(Example: Heart Murmur, Prosthetic Hips and Knees) If YES please list:

_____

_____

_____

Tobacco: ☐ Now ☐ Never ☐ In the Past, Amt Per Day_____ Age Started _____ Year Quit _____

Alcohol: ☐ Never ☐ Rare ☐ Occasional ☐ Moderate ☐ Heavy, Amt/ Type per day _____

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Family History & Review of System

List of all major illnesses in your immediate family (Examples: heart disease, prostate cancer, kidney stones, kidney disease):

Father :_____ ■ Prostate Cancer

Mother : _____ ■ Kidney Stones

Brother : _____

Sister :_____

Have you experienced any of the following problems recently? **Check YES or NO**

Constitutional Symptoms			**Sight/Sound**			**Ear/Nose/Throat/Mouth**		
Fever	■ Y	■ N	Blurred Vision	■ Y	■ N	Ear Infection	■ Y	■ N
Chills	■ Y	■ N	Glaucoma	■ Y	■ N	Sore Throat	■ Y	■ N
Headaches	■ Y	■ N	Loss of Hearing/Ringing	■ Y	■ N	Difficulty Swallowing	■ Y	■ N
Integumentary			**Pulmonary**			**Circulatory**		
Skin Rash	■ Y	■ N	Wheezing	■ Y	■ N	Chest Pain	■ Y	■ N
Boils	■ Y	■ N	Frequent Cough	■ Y	■ N	High Blood Pressure	■ Y	■ N
Persistent itch	■ Y	■ N	Shortness of Breath	■ Y	■ N	Varicose Vein	■ Y	■ N
Gastrointestinal			**Genitourinary**			**Neurological**		
Hepatitis	Y	N	Kidney Failure	Y	N	Dizziness	■ Y	N
Ulcer/Reflux	Y	N	Kidney Stone	Y	N	Migraine	■ Y	N
Constipation	Y	N	Urinary Tract Infection	Y	N	Multiple Sclerosis	■ Y	N
Musculoskeletal			**Endocrine**			**Hematologic/Lymphatic**		
Back pain/ Surgery	Y	N	Diabetes	Y	N	Lymph Node Swelling	■ Y	N
Muscle Disorder	Y	N	Thyroid Disease	Y	N	Bleeding Disorder	■ Y	N
Joint Disorder	Y	N	Parathyroid	Y	N	Immune disorder	■ Y	N

Other:

OB/GYN History (Female Patients Only):

Menses: ■ **YES** ■ **NO** **Hysterectomy:** ■ **YES** ■ **NO** **Number of Pregnancies:**_____**Live Births:** _____

Contraception: ■ None ■ Tubal Ligation Other: _____ Take Estrogens: ■ YES ■ NO

Any Other Information that you like to share:

Patient Signature: _____ **Date:** _____