Lubbock Urology Clinic, L.L.P.

PATIENT REGISTRATION FORM

Today's Date: _____

PATIENT INFORMATION

☐ Male ☐ Female Marital Status ☐ Single ☐ Divorced ☐ Married ☐ Widowed

Last Name: _____ First Name: _____ Middle Int. _____ DOB ____/____/_____

Social Security # _____-_____-_____ Driver's License # _____ State Issued _____

Ethnicity ☐ Hispanic ☐ Not Hispanic ☐ Declined ☐ Unknown Language _____

Race ☐ American Indian/Alaska Native ☐ Asian ☐ Nat. Hawaiian/Pacific Islander ☐ African American ☐ White ☐ Other ☐ Declined ☐ Unknown

Address _____ City _____ State _____ Zip _____

Primary Phone (_____) _____ Secondary Phone (_____) _____ Email _____

Employer _____ Occupation _____ Employer's Phone _____

Emergency Contact _____ Relationship _____ Phone (_____) _____

What is your *preferred method* for receiving notices about your follow up care such as lab results? ☐ Email/Portal ☐ Mail ☐ Phone Call

Pharmacy Name:_____ Phone #: _____

Pharmacy Address:_____ City; _____ State: _____ Zip: _____

REFERRAL INFORMATION

Primary Care Physician_____ Phone (_____) _____

Referred by: ☐ Doctor ☐ Relative ☐ Friend or ☐ Other

EMERGENCY HEALTH / INFORMATION RELEASE

Lubbock Urology Clinic, LLP and its staff has my permission to discuss my account or medical conditions which may include symptoms, tests, treatments, medicine or other protected health information with the following persons to facilitate my treatment and payment of my account.

_____

Name Relationship Phone

_____

Name Relationship Phone

I understand authorizing the release of this information is voluntary and does not affect my access to treatment. I can refuse to make this authorization. I understand this authorization will remain effective until I revoke it by completing a new form. I understand if this information is shared with these individuals above, that they may disclose my protected health information to other individuals. I have indicated my agreement with this authorization by signing below.

INSURANCE INFORMATION

INSURANCE INFORMATION MUST BE COMPLETELY FILLED OUT
(A copy of your insurance card (s) will be taken by the receptionist)

Primary Insurance _____Group No._____ ID No._____ Co-Payment $ _____

Secondary Insurance _____ Group No. _____ ID No. _____

Does Your Insurance Require a Referral? ☐ Yes ☐ No Do You Have A Waiting Period? ☐ Yes ☐ No How Long? _____

If the name on the insurance card is not the patient, complete the section below

Insured Name:_____ DOB ___/_____/_____ Phone (_____)_____

Address _____ City _____ State _____ Zip _____

☐ Male ☐ Female Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Employer: _____ Insured Social Security # _____-_____-_____Effective Date of Insurance:_____

I accept full responsibility for all charges for service rendered by Lubbock Urology Clinic, LLP. I agree to pay all costs of collections, including reasonable attorney fees. I authorize the release of any medical information necessary for the completion of insurance claim forms. I assign all benefits under my current health insurance policies and authorize payment directly to Lubbock Urology Clinic, LLP of any medical or government benefits due from my insurance and/or government program. I understand my insurance may not pay all my charges and I agree to promptly pay the difference or the entire bill. I have received a copy of the Notice of Privacy Practices statement. I have authorized Lubbock Urology Clinic, LLP to discuss my protected health information with the above named individuals.

_____

Patient's or Authorized Representative's Signature Date

INSURANCE IS FILED AS A COURTSEY. CO-PAYMENTS,CO-INSURANCE AND DEDUCTIBLES ARE EXPECTED AT TIME OF SERVICE-THANK YOU

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