Patient Registration & Insurance Information

Please present insurance card and photo ID for us to copy.

Date ________________________ Physician ______________________________

Person Responsible for Bill

Guarantor Name____

Address ____

City, State, ZIP ____

Home Phone # _______________________ Work Phone #_____________________

Relation to Patient _____________________

Patient Information

Name ____

Address ____

City, State, ZIP ____

Home Phone #_______________________ Work Phone #______________________

Cell Phone #________________________ Email __________________________

Date of Birth ______________________ Sex ________ Marital Status __________

Race: ❑ Black, African American ❑ Asian ❑ White ❑ American Indian, Alaska Native
❑ Native Hawaiian, Other Pacific Islander ❑ Unknown ❑ Declined

Ethnicity: ❑ Hispanic or Latino ❑ Not-Hispanic or Latino ❑ Unknown ❑ Declined

Primary Language_______________________

Social Security Number ___________________________

(If a minor): Mother's Name__________________________Home Phone #__________

Father's Name __________________________ Home Phone #__________

Emergency Contact Information

Contact Name ____

Relationship to Patient ____

Address ____

City, State, ZIP ____

Home Phone # _______________________ Work Phone #_____________________

Primary Insurance Name

Insurance Name ____

Group #_________________________ Policy # ___________________________

Subscriber Name ____

Patient Relation to Subscriber ______________________Date of Birth______________

Social Security Number ___________________________

Employer ________________________________ Work Phone # _______________

Secondary Insurance Name

Insurance Name ____

Group #_________________________ Policy # ___________________________

Subscriber Name ____

Patient Relation to Subscriber ______________________Date of Birth______________

Social Security Number ___________________________

Employer ________________________________ Work Phone # _______________

Referred by ____________________________________

BAPTIST Urology Group

Authorizations and Acknowledgments

We are committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Please ask us if you have any questions about our fees, financial policy, or your payment responsibility.

All new patients will be asked to provide patient information prior to being seen by the physician. We also may ask to make a copy of any type of picture identification to remain a permanent part of your chart.

Insurance Information

- If you are covered by Medicare,Tricare or any of our managed plans, we will file your insurance claim. You are responsible for any co-pay, co-insurance, deductible, or non-covered services at the time of your visit. If we do not participate with your insurance company, you will be responsible for full payment at the time of your visit. **Methods of Payment: Cash, Check, Visa, Mastercard and Discover.**
- All self-pay patients are expected to pay for services in full at the time that services are rendered.
- We will file with all insurance plans for our professional fees for any hospital admissions.
- In the event your insurance company does not pay the full balance within 90 days, we will notify you so that you may contact your insurance carrier. Please remember that ultimately, payment responsibility rests with the patient.
- Please advise the office personnel of any changes in your insurance or mailing address.
- Should it ever become necessary to use the services of a collection agency to collect your account, you would be responsible for any costs incurred for that purpose.

Worker's Compensation

Worker's Compensation patients will be seen only after the proper authorization and paperwork has been received.

Unaccompanied Minors

The parents (or guardians) will be responsible for full payment unless covered by a participating managed plan. Authorization to treat an unaccompanied minor must be on file.

Completion of Forms

Baptist Health reserves the right to charge a nominal fee for the completion of disability and/or Family Medical Leave forms.

Authorization for Payment

I hereby authorize Baptist Health to bill my insurance company directly for these services. I understand I am financially responsible for charges not covered by my insurance company. I authorized any holder of medical or other information about me to release to the Social Security Administration or intermediaries any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical benefits either to myself or to the party who accepts assignment. I certify that the above information is currently correct.

Responsible Party Signature ____________________ Date ____________

Patient's Name (Please Print)) ____________________ Date of Birth ____________

Notice of Privacy Practices

I acknowledge receipt of a copy of the Baptist Health Notice of Privacy Practices (NPP) either at this time or previously. By accepting services at Baptist Health, I authorize Baptist Health to use and disclose information from and release copies of my (the patient's) medical records in accordance with Baptist Health's policies and privacy practices, which are summarized in the NPP, including disclosure to my (the patient's) past, present and future healthcare providers.

Patient or Parent (Guardian) ____________________ Date ____________