Arizona State Urology

(Subsidiary of Glendale Urology PC)

PATIENT REGISTRATION

PLEASE PRINT AND COMPLETE ALL ENTRIES

PATIENT NAME (LAST -- FIRST -- MIDDLE INITIAL)	ADDRESS		
CITY, STATE	ZIP	HOME PHONE	CELL PHONE
BIRTHDAY (M/D/Y) / PATIENT SSN	SEX ❑ Male ❑ Female ❑Other_____	MARITAL STATUS ❑ Single ❑ Married ❑ Other_____	EMAIL (REQ-PORTAL)
PATIENT EMPLOYER NAME	PATIENT EMPLOYER ADDRESS (STREET ADDRESS - CITY - STATE - ZIP)	EMPLOYER PHONE	

INSURED/RESPONSIBLE PARTY INFORMATION RELATION TO PATIENT: ❑spouse ❑parent ❑guardian

NAME (FIRST -- LAST -- MIDDLE INITIAL)	ADDRESS (if different from patient)			
HOME PHONE	WORK PHONE	SSN	BIRTH DATE	EMPLOYER

INSURANCE INFORMATION

PRIMARY INSURANCE NAME	ADDRESS (STREET - CITY - STATE - ZIP)	PHONE	
GROUP NUMBER	ID NUMBER	EMPLOYER	EMPLOYER PHONE
SECONDARY INSURANCE NAME	ADDRESS (STREET - CITY - STATE - ZIP)	PHONE	
GROUP NUMBER	ID NUMBER	EMPLOYER	EMPLOYER PHONE

PRIMARY DOCTOR/FAMILY DOCTOR	REFFERING DOCTOR	
IN CASE OF EMERGENCY CONTACT	RELATIONSHIP	PHONE NUMBER

ASSIGNMENT AND RELEASE (Please Initial Before Each Line)**:**

_____ I understand that I have medical insurance which when billed on my behalf should pay for their portion of my office visits and treatment charges.

_____ I will inform Arizona State Urology or Ironwood Physicians PC of a change in my insurance coverage.

_____ I understand the billing process may take 4-6 weeks at which time my insurance company will determine and pay for services per my contract.

_____ I understand that it is my responsibility to pay all co-pay, deductible and estimated co-insurance amounts at the time of service rendered and remaining balance as determined by my insurance company.

_____ I understand that my credit card information will be kept on file and that if I do not pay within 60 days after my insurance has paid, I acknowledge that Ironwood Physicians, PC will charge the balance to the credit card on file.

_____ I understand that if for any reason my insurance company does not pay for the covered services within 90 days of the services provided, I shall assume responsibility for the total amount owed, which may be charged to the credit card on file.

_____ I thereby assign all medical benefits directly to Ironwood Physicians PC for services rendered at their facilities.

_____ I understand if a CT or PET/CT scan is completed it will be necessary for a licensed Radiologist to interpret or read my scan results. I will receive two statements for my CT or PET/CT scan. One for the professional interpretation of the CT or PET/CT scan which is separate from Ironwood.

_____ We may request proof of insurance premium payment.

SIGNATURE (Patient or, if minor Signature of parent or guardian)	DATE

PLEASE PRINT AND COMPLETE ALL ENTRIES

PATIENT NAME (LAST -- FIRST -- MIDDLE INITIAL)	Date

Authorization to release health information to:

Name-Emergency Contact (s)	ADDRESS		
CITY, STATE	**ZIP**	**HOME PHONE**	**DAYTIME PHONE**
DATES OF SERVICE **FROM:** **TO:**	**AUTHORIZATION EXPIRES (UNLESS OTHERWISE NOTED THIS AUTHORIZATION WILL REMAIN IN EFFECT ONE YEAR FROM THE DATE SIGNED)** ❑ **NEVER** **DATE:**		

Release the following information:

❑ **All Records** ❑ **Chart Notes** ❑ **Radiology Reports** ❑ **Operative Reports** ❑ **History & Physicals**

Name-Additional Contact (s)	ADDRESS		
CITY, STATE	**ZIP**	**HOME PHONE**	**DAYTIME PHONE**
DATES OF SERVICE **FROM:** **TO:**	**AUTHORIZATION EXPIRES (UNLESS OTHERWISE NOTED THIS AUTHORIZATION WILL REMAIN IN EFFECT ONE YEAR FROM THE DATE SIGNED)** ❑ **NEVER** **DATE:**		

Release the following information:

❑ **All Records** ❑ **Chart Notes** ❑ **Radiology Reports** ❑ **Operative Reports** ❑ **History & Physicals**

RELEASE OF INFORMATION

I understand that:

- Once Arizona State Urology and/or Ironwood Physicians PC discloses my health information by my request, we cannot guarantee that Recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state laws governing the use and disclosure of my health information.
- I may make a request in writing at any time to inspect and/or obtain a copy of my health information maintained at this facility as provided in the Federal Privacy Rule 45 CFR (164.524).
- My records are protected and cannot be disclosed without written permission
- I hereby authorize Arizona State Urology and Ironwood Physicians PC to use and disclose my personal health information to the individuals identified on this form. I understand this authorization does not expire unless written notice is mailed to P.O. Box 6423 Chandler AZ, 85246. I understand this may include information relating to communicable diseases, such as HIV/AIDS, sexually transmitted diseases, behavioral or mental health, alcohol and/or drug abuse treatment, and genetic testing information, if any records exist. I understand that Ironwood Physicians PC will treat the individuals identified on this form as individuals involved directly in my care and as such, Ironwood Physicians PC will be allowed to release my personal health information to these individuals for the purposes of treatment, payment and healthcare operations. I have read and received a copy of the above statements and accept the terms. A duplicate of the statement is considered the same as the original. I voluntarily sign this authorization, and I understand that my ability to obtain health care from Arizona State Urology and/or Ironwood Physicians PC will not be affected if I refuse to sign this authorization.

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE	DATE	EMAIL
IF SIGNED BY LEGAL REPRESENTATIVE, RELATIONSHIP TO PATIENT	**SIGNATURE OF WITNESS (Optional):**	

RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand that:

- Arizona State Urology and Ironwood Oncology PC share the same commitment to protecting your privacy and ensuring that your health information is used and disclosed properly. This Notice of Privacy Practices identifies all potential uses and disclosures of your health information by our practice and outlines your rights with regard to your health information. Please sign the form below to acknowledge that you have received our Notice of Privacy Practices.
- I acknowledge that I have received a copy of the Notice of Privacy Practices of Ironwood Oncology P.C.

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE	DATE	EMAIL
IF SIGNED BY LEGAL REPRESENTATIVE, RELATIONSHIP TO PATIENT	**SIGNATURE OF WITNESS (Optional):**	