Urology Specialists

Patient Registration, Confidential Communications, & Consent for Treatment

Today's Date _____ **MRN** _____

Patient Information			
Last Name	First Name	Middle Name	Preferred Name
SSN	DOB	Sex	Preferred Phone #
Mailing Address	City	State	Zip Code
Marital Status	Race	Preferred Language	Email Address
Primary Employer, Address, and Phone Number			
Emergency Contact, Relationship, and Phone Number			
Primary Physician (to whom records will be sent), City, State, and Phone Number			

Responsible Party/Guarantor (if different from above)			
Name	Relationship	DOB	Phone Number
Address	City	State	Zip Code

Release of Verbal Communications & Insurance Information			
I request Urology Specialist to keep communications regarding my protected health confidential. To accomplish this, please adhere to the following:			
Patient Preferred Phone #	Home, Mobile, or Work?	Permission to leave a message? **Yes or No**	Patient lives in a Nursing Home, Group Home, or Assisted Living? **Yes or No**
Name/relationship of contact we can share information with:	Contact Phone Number:	Name/relationship of contact we can share information with:	Contact Phone Number:
Primary Insurance		Secondary Insurance	

HIPPA Privacy Policy & Patient Rights, Insurance Authorization, Ownership Interest Disclosures

- As a prospective patient at USC Ambulatory Surgical Center (USC ASC), we inform you; our Ambulatory Surgical Center is owned by Urology Specialists Clinic (USC), which is owned by the physicians of USC. The USC physicians and/or family members have 100% ownership interest in USC ASC
- As a prospective patient at Sioux Falls Specialty Surgical Center (SFSH), we inform you; SFSH is partially owned by the physicians of USC and meets federal definition of a physician owned hospital as specified in 42 CFR 489.3. The USC physicians have the following ownership in SFSH: <10%.
- You have the right to choose the provider of your services. Therefore, you have the option to use a health care facility of your choice. You will not be treated differently by your physician if you choose to use a different facility. If desired, your physician can provide information of alternative providers.
- I understand a copy of HIPPA Privacy Policy and USC Patient Rights and Responsibilities is available to me upon request.
- I understand it is my responsibility to provide my insurance information and USC will bill my insurance provided. I authorize my insurance benefits be paid to Urology Specialists/USC Ambulatory Surgical Center and recognize I am financially responsible for any remaining balance. I authorize release of any information requested by my insurance company.
- I consent to receive direct mail and email communication from USC. This includes for purposes of marketing disease/treatment options. I will inform USC if I wish to opt out at any time.

Medicare Insured Patients only: I request payment of authorized Medicare Benefits be made at Urology Specialists/USC Ambulatory Surgical Center. I authorize any holder of Medical information about me, needed to determine those benefits or the benefits of payable for related services, to be released to the health Care financing Administration or its agents. I also authorize Medicare to send Explanation of Medicare Benefits information to my Medicare Supplement and Benefits to be paid to urology Specialists/USC Ambulatory Surgical center, for any services furnished to me until further notice.

By signing, you indicate you have read and understand the foregoing notices

Signature _____ **Date**_____

Patient Representative Signature_____ **Relation**_____