# Arizona State Urology, PLLC

**(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<br>❑ Male<br>❑ Female<br>❑Other_______________ | MARITAL STATUS<br>❑ Single<br>❑ Married<br>❑ 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, P.L.L.C. 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 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<br>FROM: TO: | AUTHORIZATION EXPIRES (UNLESS OTHERWISE NOTED THIS AUTHORIZATION WILL REMAIN IN EFFECT ONE YEAR FROM THE DATE SIGNED)<br>❑ 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<br>FROM: TO: | AUTHORIZATION EXPIRES (UNLESS OTHERWISE NOTED THIS AUTHORIZATION WILL REMAIN IN EFFECT ONE YEAR FROM THE DATE SIGNED)<br>❑ 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, PLLC 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, PLLC 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, PLLC 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, PLLC 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): | |