UROLOGY TREATMENT CENTER
A Division of 21st Century Oncology, LLC

*VERIFIED BY*_____

# *PATIENT REGISTRATION*

PATIENT ACCT. #_____ (Please Complete ALL Information) DATE:_____

**ALLERGIES:**

_____

_____

_____

_____

_____

***PRINCIPAL PAYOR CODE***

| | |
|---|---|
| A. Medicare | H. Workman's Comp |
| B. Medicare HMO | I. Champus |
| C. Medicaid | J. VA |
| D. Medicaid HMO | K. Other State/Local Govt. |
| E. Commercial | L. Self-Pay (No Insurance) |
| F. Commercial HMO | M. Other |
| G. Commercial PPO | N. Charity |

**Last Name:**_____ **Date:**_____

**First Name:**_____ **M.I.:**_____ **Home Phone #:**_____

**Street Address:**_____ **Work Phone #:**_____

**Apartment #:**_____ **Date of Birth:** _____

**City:**_____ **State**_____ **Social Sec. #:** _____

**Zip Code:**_____ **Sex:** M / F **Marital Status:**_____

**Employer:**_____ **Spouse Name:** _____

**Secondary Address:**_____ **Spouse DOB:** _____**SS #**_____

**City:**_____ **State:** _____ **Zip:** _____ **Secondary Phone:**_____

**Friend/Family not living with Patient:**_____**Phone:**_____

**Address**_____**City:**_____**State:** _____ **Zip:** _____

**Referring Doctor Name**_____

***INFORMATION RELEASE***

***LIFETIME* MEDICARE B signature authorization for services beginning** _____.
**I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers, or the billing agent for Urology Treatment Center, 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 insurance benefits either to myself or to the party who accepts assignment.**

**PATIENT'S SIGNATURE:**_____**MEDICARE #**_____ **DATE:** _____

***If patient is unable to sign, may be signed by someone who is authorized by patient to sign for him/her:***

**BY:**_____ **Relationship to Patient:**_____ **DATE:** _____

**IF PATIENT IS A MINOR: I**_____ **, the**_____ **of** _____
**hereby personally accept financial responsibility for professional services by Urology Treatment Center, upon the aforementioned child.**

**SIGNED:** _____ **DATE:** _____

***ASSIGNMENT AND RELEASE***

**I/We hereby authorize my insurance benefits, including Medicare Gap Fillers, to be paid directly to the physician and I/We hereby agree to be financially responsible for any amount not covered by insurance. I further understand that if this account is referred to an agency or attorney for collection, I will be responsible for all fees associated with collection. I/We also authorize the physician to release any information required. Financial information can be released if the Patient's account number is provided by the person making the request.**

**PATIENT'S SIGNATURE:**_____ **DATE:** _____

***If patient is unable to sign, may be signed by someone who is authorized by patient to sign for him/her:***

**BY:**_____ **Relationship to Patient:**_____ **DATE:** _____

**SPOUSE'S SIGNATURE:**_____ **DATE:** _____