

UROLOGIC INSTITUTE OF NEW JERSEY, P.A.

REGISTRATION

(Please Print)

DATE: _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

PATIENT NAME:

(Last) _____ (First) _____ (Middle Initial) _____

Street Address: _____ Apartment _____

City: _____ State _____ Zip Code _____

Sex M ___ F ___ Age _____ Date of Birth _____ Martial Status _____

SS # _____

INSURANCE STATUS:

Patient Employed By: _____ Occupation: _____

Business Address: _____

Name of Primary Insurance: _____ ID#: _____

Group#: _____ Subscriber: _____ Birthdate: _____ Relationship _____

Name of Secondary Insurance: _____ ID#: _____

Group#: _____ Subscriber: _____ Birthdate: _____ Relationship _____

EMERGENCY NOTIFICATION:

In case of emergency, who should be notified? _____ Phone: _____

I hereby give permission to disclose personal health information to: _____

Relationship: _____ Telephone #: _____

PRIMARY PHYSICIAN CONTACT:

Primary Care Physicians Name: _____ Telephone _____

Address _____ City: _____ State: _____

Telephone #: _____ Fax #: _____

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Patients Name _____

INSURANCE PAYMENT AUTHORIZATION

I, the undersigned, have insurance coverage with _____
(Name of Insurance Company)

and assign directly to Drs. Vitenson/Rome/Rusnack/Lebovitch all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

Signature of Insured: _____ **Date** _____

MEDICARE PAYMENT AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Drs. Vitenson/Rome/Rusnack/Lebovitch for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is only responsible for the deductible, coinsurance and noncovered services. Coinsurance and the deductibles are based upon the charge determination of the Medicare carrier.

Signature of Insured: _____ **Date** _____