

Patient Registration

Andover Urology

First: _____ Middle: _____ Last: _____

Address: _____ City: _____

State: _____ Zip: _____ Date of Birth: _____

Phone: Home (_____) _____ - _____ Work (_____) _____ - _____ Cell (_____) _____ - _____

Sex: M circle one F Marital Status: M W D S Social Security #: _____ - _____ - _____

Primary Care Physician: _____

Referring Physician: _____

Patient Employer: _____

Address: _____

Guarantor (Name): _____ DOB: _____ S.S.# _____

Address: _____

Emergency Contact : _____ Phone: (_____) _____ - _____

Primary Insurance: _____ Subscriber: _____

Date of Birth: _____ Employer: _____

Policy Number: _____ Group Number: _____

Secondary Insurance: _____ Subscriber: _____

Date of Birth: _____ Employer: _____

Policy Number: _____ Group Number: _____

Insurance Authorization and Assignment

I, hereby authorize Andover Urology Associates P.C. to furnish information to insurance carriers concerning my illness and treatments and I hereby assign to the physician all payments for medical services rendered. I understand that I am responsible for any amount not covered by my Insurance(s).

Date: _____ Signature: _____



Andover Urology

Stephen M. Zappala, M.D., F.A.C.S.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

I, _____ acknowledge that I have received a copy of Andover Urology Notice of Privacy Practices. This notice describes how Andover Urology may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

_____/_____/_____
(Signature of Patient or Personal Representative) (Date)

(Relation to Patient)

PATIENT RECORD OF DISCLOSURES

In general the HIPPA privacy rule gives individuals the right to request restrictions on disclosure of their PHI (private health information). It also requires health care providers to take reasonable steps to limit the use or disclosure of protected health information. Therefore we are asking you to list anyone whom **you do** want your PHI made available to. This includes phone and written correspondence, i.e.: phone conversations, messages, mailers and appointment reminders.

The following people **are allowed** to receive information regarding my PHI (private health information):

1. _____
2. _____
3. _____

Patient/Gaurdian Signature: _____

Today's Date: _____



Andover Urology

Stephen M. Zappala, M.D., F.A.C.S.

Our Financial Policy

We are committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, Financial Policy or your responsibility.

- All patients must complete our "Patient Information Form" before seeing the doctor.
- Full payment is due at time of service (unless we have contracted with your insurance carrier for your particular service. After full payment is made, you will receive a receipt with all the necessary information for your reimbursement by your own insurance carrier).
- We accept cash, check and Visa/MasterCard/Discover
- Patients are responsible for full payment at time of service.
- Non-Emergency Treatment may be denied if:
 - A minor under eighteen is unaccompanied by an adult
 - A patient that does not have a valid insurance card.
 - A referral is not obtainable when required by the insurance.
 - A patient has been delinquent on balance and/or the account has been sent to our "Collection" agent.
 - A patient has missed more than three previous appointments and had been advised of being denied another appointment.

I understand that my insurance carrier may require a referral from my Primary Care Physician as authorization for treatment. It is **my responsibility** to obtain this referral. If a claim is denied by my insurance carrier for failure to obtain, **I** will be held responsible for full balance of the claim.

I, _____ have read
(Please Print)

and understand the conditions for payment to Andover Urology as outlined above.

Signature: _____ Date: _____



Andover Urology

Stephen M. Zappala, M.D., F.A.C.S.

Patient Health Survey

Name: _____ Referring Physician: _____

Date of Birth: ___ / ___ / ___ Age: _____ Weight: _____

Hospitalizations, Medical or Surgical problems:

Medication: _____

Allergies: _____

Are you allergic to Intravenous contrast, dye, or IVP dye? Yes _____ No _____

Family History of Medical Problems: _____

Do you smoke? No _____ Yes _____ quantity _____

Do you drink? No _____ Yes _____ quantity _____

Reason for consultation: _____

