

## PATIENT REGISTRATION

Thank you for choosing our office! In order to serve you properly, we need the following information.

**PLEASE PRINT.** All information will be confidential.

Doctor: \_\_\_\_\_

Chart # \_\_\_\_\_

Patient Name \_\_\_\_\_  
LAST FIRST MIDDLE INITIAL

Address \_\_\_\_\_  
STREET CITY STATE ZIP CODE

Home Phone (\_\_\_\_\_) \_\_\_\_\_ Work/Cell Phone (\_\_\_\_\_) \_\_\_\_\_ Extension \_\_\_\_\_

Birth date \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security # \_\_\_\_\_  Male  Female  
mm dd yyyy

Check the appropriate box:  Single  Married  Separated  Divorced  Widowed

Check the appropriate box:  Employed  Retired  Other

Referring Physician's Name \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_

Family Physician's Name \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_

Worker's Compensation?  Yes  No

### Primary Insurance Information

**(COPAYS ARE DUE AT THE TIME OF SERVICE)**

Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_ ID # \_\_\_\_\_

Name of Insured \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Birth date \_\_\_\_/\_\_\_\_/\_\_\_\_ Insured Phone \_\_\_\_\_ Insured Social Security # \_\_\_\_\_

### Secondary Insurance Information

Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_ ID # \_\_\_\_\_

Name of Insured \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Birth date \_\_\_\_/\_\_\_\_/\_\_\_\_ Insured Phone \_\_\_\_\_ Insured Social Security # \_\_\_\_\_

### Patient Authorization

I, \_\_\_\_\_ hereby authorize Northern Virginia Urology to apply for benefits on my behalf for covered services rendered. I request payment from Medicare and/or \_\_\_\_\_ Insurance Company be made directly to Northern Virginia Urology.

I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claim, to the above-named billing agent, (or in the case of Medicare Part B benefits, to the Social Security Administration and Health Care Financing Administration) and/or the insurance company named above. I permit a copy of this authorization to be used in place of the original until I or the above-named carrier at anytime in writing may revoke this authorization. I agree to promptly pay all charges when billed for medical services rendered and accept legal responsibilities for any and all charges.

**Most managed care insurance plans require referrals from your primary care physician. I agree that it is my responsibility to obtain the referral. If I do not bring my referral, I agree that payment is due on the date of service or my appointment will be rescheduled.**

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient's or Legal Guardian Signature

PLEASE TURN OVER 

## Northern Virginia Urology, PLLC

**I acknowledge that the information provided is true and accurate and Northern Virginia Urology has my permission to submit health claims to the insurance company for claims processing and assignment of benefits. I acknowledge the financial policy as outlined here.**

I understand that my health insurance carrier may not pay for certain charges generated for services delivered by Northern Virginia Urology. This denial may occur even when my provider believes certain services are medically necessary based on the prevailing standard of good medical care. These non-covered services may include, but are not limited to the evaluation of, diagnostic testing for and management of: erectile dysfunction, infertility, screening for cancer, and screening for sexually transmitted disease. I acknowledge that it will be my responsibility to pay for charges and costs incurred in total.

As a courtesy, physician shall file patient's medical claim with patient's insurance company. (If we participate) Patient agrees that if insurance plan requires a referral from their primary care physician, then it is the **patient's responsibility to obtain the referral** and further that if patient does not obtain the referral, then the patient shall reschedule the appointment. Patient further agrees to make all co-payments at the scheduled appointment time. Patient agrees that if any or all of the information concerning insurance coverage changes, patient will immediately inform physician's business office and provide the updated information.

I also understand that I will be responsible for administrative fees charged, \$25.00 for all other office appointments cancelled within 24 business hours or failure to keep any scheduled appointment, \$100.00 for any office procedure and \$200.00 for all hospital procedures cancelled within 48 business hours. The fee for cancelled checks of insufficient funds will be \$25.00. Patients will be responsible for copying fee of 50 cents per page for 1-50 pages, 25 cents for each page thereafter and a clerical fee of \$10.00 for reproduction of medical records. There will also be a charge for the preparation of life insurance, disability insurance and all other forms requiring staff or physicians work product, beginning at \$30.00.

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Patient Signature

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Date

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Patient's Printed Name

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Waiver NVU Initials

# Northern Virginia Urology, PLLC

## NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

PLEASE TURN OVER



# Northern Virginia Urology, PLLC

## PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

*I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: \_\_\_\_\_

Signature \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Date: \_\_\_\_\_ **Consent expires one year from this date.**

### EMERGENCY CONTACT(S)

\_\_\_\_\_  
Name Relationship to Patient Phone Number(s)

\_\_\_\_\_  
Name Relationship to Patient Phone Number(s)

### RELEASE OF INFORMATION

I, the undersigned, authorize the physicians and staff of Northern Virginia Urology to speak with the persons listed below regarding my medical care. I understand that with my signature I am authorizing the release of written or oral communication by Northern Virginia Urology to the listed persons and thereby release the physicians and staff of Northern Virginia Urology from all legal responsibility that may arise from the act hereby authorized. (Etc. spouse, children, parents)

\_\_\_\_\_  
Authorized Person Relationship to Patient Phone Number(s)

\_\_\_\_\_  
Authorized Person Relationship to Patient Phone Number(s)

\_\_\_\_\_  
Patient's Signature Date

