

**REGISTRATION FORM (PLEASE PRINT)**

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| --- | --- |
| Primary Care/Referring Doctor: | Today’s Date: |
| **PATIENT INFORMATION** |
| Patient’s Last Name: First: Middle: | Age: |  Male Female | Date of Birth:/ / |
| Street Address: | Social Security No.: | Best Contact Phone Number:( ) |
| City: | State: | ZIP Code: | Secondary Phone Number:( ) |
| Ethnicity:Hispanic or LatinNot Hispanic or LatinRefuse to Report | Race: American Indian or Alaska Native White  Asian Hispanic Native Hawaiian Other Race Black or African American Other Pacific Islander |
| Primary Parent / Guardian Name: | Email: |
| Social Security No.: | Date of Birth: |
| Employer: | Employer phone No.: ( ) |
| Second Parent / Guardian Name: | Marital Status of Parents:  Married Divorced Single |
| **INSURANCE INFORMATION** |
| Name of Primary Insurance: | Subscriber’s Name: | Birth Date:/ / | Subscriber’s S.S. No.: | Policy No.: | Group No.: |
| Subscriber Address:If different than above | Patient’s relationship to subscriber:Self Spouse Child Other |
| City: | State: | ZIP Code: |
| Name of Secondary Insurance: | Subscriber’s Name: | Birth Date:/ / | Subscriber’s S.S. No.: | Policy No.: | Group No.: |
| Subscriber Address:If different than above | Patient’s relationship to subscriber: Self Spouse Child Other |
| City: | State: | ZIP Code: |
| **EMERGENCY CONTACT** |
| Last Name: First: Middle: | Home Phone Number : ( )Cell Phone Number: ( ) |
| Street Address: | Relationship to Patient: | Email: |
| City: | State: | ZIP Code: |
| **APPOINTMENT INFORMATION** |
| Referred by (Full name): | Reason for today’s visit: |

**My signature below affirms my patient registration information is complete and true.**

Signed: Relationship: Date

**Consent to Treat**

I hereby consent to evaluation, diagnostic procedures, testing, and treatment as directed my physician or his/her designee.

I give my consent for the licensed health care professionals of Elevate Partnership, PLLC/ Austin Urogynecology to examine my person, perform medical diagnostic studies and give medical treatment which is consistent with the standards of medical care. I understand that this **Consent to Treat** will be valid for each visit I make to the Elevate Partnership, PLLC/ Austin Urogynecology until revoked by me in writing.

**Recalls**

Recalls are a courtesy and not guaranteed to be sent out. It is the patient or patient guardian’s responsibility to set up all follow up and

yearly appointments.

**Contact/ Release of Information**

In the event that Elevate Partnership, PLLC/ Austin Urogynecology need to contact you regarding an appointment, lab result, medication or for any other reason, it is permissible to:

 Leave a message on an answering machine/ Voicemail  Speak with spouse/ significant other

 Other: Name Relationship to Patient:\_

 Speak with other family member

I acknowledge that Elevate Partnership, PLLC/ Austin Urogynecology may release my protected health information as necessary for treatment, payment and health care operations and acknowledge that Elevate Partnership, PLLC/ Austin Urology Institute/ Austin Urogynecology’ s Notice of Privacy Practice provides information on how my protected health information may be used and/or disclosed for these purposes. I understand that protected health information pertains to my diagnosis and/or treatment, and includes, but is not limited to, information related to my health history, diagnosis, treatment, prognosis, mental illness (excluding psychotherapy notes) , use of alcohol or drugs, prescriptions and laboratory test results, including HIV or the diagnosis of AIDS.

I understand that use or disclosure of my protected health information may be necessary before my insurer will pay for the cost of my medical treatment and that if I refuse to consent to this disclosure I may be required to pay the entire cost of medical care provided by my provider.

I acknowledge and consent to allow Elevate Partnership, PLLC/ Austin Urogynecology to use health information exchange systems to electronically transmit, receive and/or access my medical information, which may include, but is not limited to, treatments, prescriptions, labs, medical and prescription history and other protected health information. I may “opt out” and not have my protected health information disclosed through health information exchange systems by providing the signed Elevate Partnership, PLLC/ Austin Urogynecology “opt-out” form to the practice location where I receive treatment.

**Financial Policy**

I assign and transfer to Elevate Partnership, PLLC/ Austin Urogynecology all rights, title and interest in payments from third-party payors, including but not limited to, health plans, health insurers, Personal Injury Protection (PIP)/Uninsured Motorist/Under Insure d Motorist (UIM/UM), auto or homeowner’s insurance. I understand that it is my responsibility to know my insurance benefits and whether or not the services I receive are a covered benefit. I understand and agree that I will be responsible for any deductible, co -pay or balance due that Elevate Partnership, PLLC/ Austin Urogynecology are unable to collect from my third-party payor for whatever reason. If my account becomes delinquent and it is necessary for the account to be referred to attorneys’ or collection agencies, or lawsuit filed, I agree to pay all patient charges, reasonable attorneys fees and collection expenses.

I authorize the release all medical information necessary to process all claims and the release of payment for medical benefits to my physician and Elevate Partnership, PLLC/ Austin Urology Institute/ Austin Urogynecology. I agree to pay any outstanding balance for services not covered by insurance, applicable copays, co-insurance, deductible, and replacement costs for items damaged.

**My signature below affirms my patient registration information and acceptance of the financial terms, responsibilities and consents as stated herein.**

Patients Name: Date of Birth:

Signature: Relationship: Date

**Insurance Card Policy**

Please present your current ***Insurance Card*** and ***Photo ID*** at check-in. Both are required to process insurance claims. Your appointment will be rescheduled to our next available opening if you do not bring these documents or if you do not obtain a referral, if required by your insurance. You are responsible for obtaining a referral from your PCP if one is required.

**Medicare/Medicaid/Insurance Benefits**

If I am eligible for health care benefits under any federal or state program, including, but not limited to Medicare or Medicaid, I certify that the information given by me in applying for payment under any such programs is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or Contractors any information needed for any federal or state program related claims. I request that payment or authorized benefits be made to Elevate Partnership, PLLC/ Austin Urogynecology on my behalf. I understand that I am financially responsible for any deductible, co-pay or balance due under these programs.

**Acknowledgement of Receipt of the Notice of Privacy Practice**

I acknowledge that I have reviewed a copy of Elevate Partnership, PLLC/ Austin Urogynecology Notice of Privacy Practices. I understand how medical information will be used and disclosed. I understand a copy will be given to me upon request.

**General Office Policies**

-The practice does not accept “walk-in” patients or appointments.

-If you are more than 15 minutes late, the physician reserves the right to reschedule your appointment.

-If you are late, and the physician agrees to see you, you will lose your appointment and be seen after those patients who arrive on time. This may result in a very prolonged wait time.

**No Show policy**

Elevate Partnership, PLLC/ Austin Urogynecology is committed to providing the highest quality care to our patients. Our staff will work hard to get you an appointment at a convenient time.

No-shows, or missed appointments, have a great impact on our ability to provide timely access to care. When a person fails to show up for their scheduled appointment or fails to give us a 24 hour notice to either reschedule or cancel their appointment, it leaves an empty time in our physician’s schedule that could have been used by a patient in need.

All scheduled appointments not cancelled 24 hours prior, are subject to a $40.00 fee. If you miss or cancel more than 2 consecutive appointments we will be unable to schedule future appointments.

**To cancel an appointment, call our office at 512-973-8276**

By signing below, you understand and agree to all policies.

Patient Printed Name Patient Date of Birth

Patient/Responsible Party Signature Date