Patient Registration Form

Items marked with an asterisk (*) are required.

PATIENTS DATA*

*First _____
M.I_____
*Last_____
* Date of Birth _____
*Sex M ____ F ____)

Marital status (Single _____ Married _____ Widowed _____)

*Address _____Apt. _____

*City _____
*State _____
*Zip _____

*Home Phone _____
*Work Phone _____
*Cell _____

*Social Security # _____
Age _____

*Spouses Name_____ *Spouses Date of Birth_____

*Who should we notify in case of emergency?_____ *Phone _____

*Pharmacy _____

Pharmacy Address:_____

Pharmacy Phone _____

*Are you currently taking medication? Yes_____ No _____

If Yes please list: _____
_____
_____

*Patients Employer _____ Phone_____

*EmployerAddress_____

Spouse's Employer_____ Phone_____

Spouses Employer
Address_____

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***

*Are you on Medicare? _____ #_____ Medicaid? _____ #_____

*PRIMARY Insurance Company_____

*Policyholders Name_____Policyholders Date of Birth_____

*ID#_____ *Group#_____

Insurance Companys Address_____

*SECONDARY Insurance Company_____

*Policyholders Name_____ Policyholders Date of Birth_____

*ID#_____ *Group #_____

Insurance Companys Address_____

*Is this visit covered by Workmans Compensation?_____
If yes, Work Comp Carrier
Address:_____

_____

Work Comp Carrier Phone #_____Date and Nature of Injury_____

*Has Your address changed? YES NO

if yes: new address:_____

*Has Your insurance changed? YES NO

if yes: new insurance name:_____

new insurance ID#:_____

new insurance group #:_____

Primary Care Provider:_____

Address of Primary Care Provider_____

Who should we thank for referring you to us?
[[zhemr_patient_data.providerID]]_____

Saratoga Urology

EMAIL CONSENT

*Patient E-mail: .....

1. RISK OF USING E-MAIL

Transmitting patient information by E-mail has a number of risks that patients should consider. These include, but are not limited to, the following:

a.E-mail can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.
b.E-mail senders can easily misaddress an E-mail.
c.Backup copies of E-mail may exist even after the sender or the recipient has deleted his or her copy.
d.Employers and on-line services have a right to inspect E-mail transmitted through their systems.
e.E-mail can be intercepted, altered, forwarded, or used without authorization or detection.
f.E-mail can be used to introduce viruses into computer systems.

2. CONDITIONS FOR THE USE OF E-MAIL

The Provider cannot guarantee but will use reasonable means to maintain security and confidentiality of E-mail information sent and received. The Patient and Provider must consent to the following conditions:

a.E-mail is not appropriate for urgent or emergency situations. The Provider cannot guarantee that any particular E-mail will be read or responded to.
b.E-mail must be concise. The Patient should schedule an appointment if the issue is too complex or sensitive to discuss via E-mail.
c.E-mail communications between patient and provider will be filed in the Patients permanent medical record or departmental file.
d.The Patients messages may also be delegated to another provider or staff member for response. Office staff may also receive and read or respond to patient messages.
e.The Provider will not forward patient-identifiable E-mails without the Patients prior written consent, except as authorized or required by law.
f.The Patient should not use E-mail for communication regarding sensitive medical or financial information.
g.It is the Patients responsibility to follow up and/or schedule an appointment if warranted.
h.Recommended uses of patient-to-provider e-mail should be limited to:
    a.Appointment requests
    b.Prescription refills
    c.Requests for information
    d.Non-urgent health care questions
    e.Updates to information or exchange of non-critical information such as routine laboratory values, immunizations, insurance changes, financial eligibility information, etc.

3. INSTRUCTIONS

To communicate by E-mail, the Patient shall:

a.Avoid use of his/her employers computer.
b.Put the Patients name in the body of the E-mail.
c.Put the topic (e.g., medical question, billing question) in the subject line.
d.Inform the Provider of changes in the Patients E-mail address.
e.Take precautions to preserve the confidentiality of E-mail and any attached documents.
f.Contact the Providers office via conventional communication methods (phone, fax, etc.) if the patient does not receive a reply within a reasonable period of time.

4. PATIENT ACKNOWLEDGMENT AND AGREEMENT

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of E-mail between the Provider and me. I consent to the conditions and instructions outlined here, as well as any other instructions that the Provider may impose to communicate with me by E-mail. I agree to use only the pre-designated e-mail address specified above. Any questions I may have had were answered.

Notice of NonDiscrimination

Saratoga Urology complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Saratoga Urology does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Saratoga Urology

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:

1. Qualified sign language interpreters
2. Written information in other formats (large print, audio, accessible electronic formats, other formats

- Provides free language services to people whose primary language is not English,such as:

1. Qualified interpreters
2. Information written in other languages

If you need these services, please call the coordinator Judy at 518-306-6184.
If you are not satisfied you can also file a civil rights complaint with the U.S. Department of Health and Human Survices,Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at: U.S. Department of Health and Human Services, 200Independence Avenue SW., Room509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 1-800-537-7697 (TDD).
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

STATEMENT OF PATIENT FINANCIAL RESPONSIBILITY

Saratoga Urology appreciates the confidence you have shown in choosing us to provide for your health care needs. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full for our fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill.

You are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. We expect these payments at time of service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. If your insurance carrier denies any part of your claim, or if you or your physician elects to continue past your approved period, you will be responsible for your balance in full.

I have read the above policy regarding my financial responsibility to Saratoga Urology, for providing services to me or the above named patient. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to Saratoga Urology, the full and entire amount of bill incurred by me or the above named patient; or, if applicable any amount due after payment has been made by my insurance carrier.

Co-Pay Policy

Some health insurance carriers require the patient to pay a co-pay for services rendered. It is expected and appreciated at the time the service is rendered for the patients to pay at EACH VISIT. Thank you for your cooperation in this matter.

Consent for Treatment and Authorization to Release Information

I hereby authorize Saratoga Urology, through its appropriate personnel, to perform or have performed upon me, or the above named patient, appropriate assessment and treatment procedures.

strike through if you do not agree

I further authorize Saratoga Urology, to release to appropriate agencies, any information acquired in the course of my or the above named patients examination and treatment.

strike through if you do not agree

Cancellation / No Show Policy

We understand there may be times when you miss an appointment due to emergencies or obligations to work or family. However, we urge you to call 24-hours prior to canceling your appointment. I understand that I will be charged a $25 fee for any missed office appointment which has not been cancelled within a 24 hour period. The office will charge me $100 for a missed appointment for an office procedure which has not been cancelled within a 24 hour period, and for a surgery which has not been cancelled within a 3 days period.

I understand if I no show for two consecutive appointments, no show for three appointments or cancel for a total of four appointments, I may be discharged from care.

Saratoga Urology will notify you in writing, via certified mail, if you are discharged from care.

I have read and understand the above information, and I agree to the terms described:

Self-Pay

O* I do not have health insurance and will be responsible for services rendered here at Saratoga Urology. I agree to pay Saratoga Urology, the full and entire amount of treatment given to me or to the above named patient at each visit.

* mark if applicable, otherwise strike through

Motor Vehicle Insurance (PIP)

O* I do not have health insurance. I request my claims be submitted to my motor vehicle carrier. I understand I will be responsible for bills incurred by me in the event my PIP benefit exhausts or denies.

* mark if applicable, otherwise strike through

Our Physicians and Staff Want You to Know How We Will Protect Your Private Health Information.

When you visit our office it is very important that you feel safe in telling your doctor personal information that may be required to fully diagnose or treat a problem. As medical professionals, please be assured that our practice has always had strict policies and procedures to protect the confidentiality of the information that you have entrusted to us. However, on April 14, 2003, new regulations became effective under a federal law called the Health Insurance Portability and Accountability Act (HIPAA). HIPAA regulations cover physicians and all other health care providers, health insurance companies and their claims processing staffs. In general, HIPAA was enacted to establish national standards to:

- Give patients more control over their health information;
- Set boundaries for the use and release of health records;
- Establish safeguards that physicians, health plans and other healthcare providers must have in place to protect the privacy of health information;
- Hold violators accountable, with civil & criminal penalties; and
- Try to balance need for individual privacy with requirement for public responsibility that requires disclosures to protect the public health.

The HIPAA rules require that our practice provide all of our patients with the attached Notice of Privacy Practices at their first visit. The Notice describes how the medical information we receive from you may be used or disclosed by our practice and your rights related to your access to this information.

Please sign below that we have provided you with a copy of the attached Notice to review. You are entitled to a personal copy of the Notice at any time to review and keep for your records. If you have any questions about our Privacy Practices, please feel free to contact our Privacy Officer.

Thank you for your cooperation.

I acknowledge that I have received a copy of the practices Notice of Privacy Practices and have been given an opportunity to ask questions.

Patient Name:_____
(Please Print)

Patient Signature _____ Date_____

Guarantor Signature _____ Date_____
(If guarantor is not the patient)

If Personal Representative, give relationship to patient:

_____

Sincerly

Dr. Matthias Solga

Return to: Saratoga Urology by fax (518-450-1279), mail (Saratoga Urology, 1 West Avcenue, Suite 215, Saratoga Springs, NY 12866), or hand deliver to: Saratoga Urology, 1 West Avenue, Suite 215, Saratoga Springs, NY 12866
Original to be retained in Medical Record Rev. 9/19

Saratoga Urology
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