GRANGER MEDICAL CLINIC | *Summit Urology*

Patient Registration Form

PATIENT INFORMATION (Please Print)

Patient's Legal Name: (Last)_____ (First) _____ (MI) _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone:_____ Cell Phone:_____Work Phone: _____

Email Address: _____ How did you hear about us? _____

Preferred method of communication for appointment reminders? ☐ Text ☐ Phone Call ☐ Email

Would you like access to your health information online? ☐ Yes ☐ No

Date of Birth: MM_____ DD _____ YYYY _____ Gender: ☐ Female ☐ Male ☐ Other

Primary Care Provider: _____ Referring Provider: _____

Language Preference: ☐ English ☐ Spanish ☐ Other _____

Employment: ☐ Not employed ☐ Employed Employer _____

Emergency Contact Name: (Last) _____ (First) _____

Relationship to Patient:_____ Phone Number: _____

Marital Status: ☐ Single ☐ Widowed ☐ Married Name of Spouse: _____

Do you have a Living Will? ☐ Yes ☐ No Do you have an Advance Directive? ☐ Yes ☐ No

Do you have health insurance? ☐ Yes ☐ No Name of Plan: _____

Policy Holder Information

Name:(Last)_____(First)_____ (MI)_____

Date of Birth: MM_____DD_____ YYYY _____

Address: _____

Name of Preferred Pharmacy: _____

Location/Address: _____Phone number: _____

******PLEASE PROVIDE YOUR INSURANCE CARD AND INFORMATION AT CHECK-IN******

CONSENT FOR TREATMENT

I hereby consent to medical treatment, diagnostic tests, laboratory or other procedures, which the physician(s) or other health care provider(s) of Granger Medical may consider or advise in my treatment, or in treatment of my dependent. This agreement will remain in effect until I choose to revoke it in writing.

Patient (If 18 years or older) or Parent/Legal Guardian Signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of Granger Medical's NOTICE OF PRIVACY PRACTICES and that it is my responsibility to read said notice to understand how my or my child(ren)'s Protected Health Information (PHI) may be used.

I understand that no authorization is required from me in order for Granger Medical to use my or my child(ren)'s PHI for purposes of treatment, payment, or health care operations. Other uses or disclosures may require my written authorization.

Patient (If 18 years or older) or Parent/Legal Guardian Signature: _____ Date: _____

(Form continues on other side)

NOTIFICATION OF APPOINTMENTS/TREATMENT/UPDATES

Granger Medical makes every effort to use your preferred method of communication for billing/appointment/treatment reminders or any other issues regarding your account and service. From time to time, we offer updates on our clinics, new medical treatments and procedures or send satisfaction surveys about your care and our providers. Contact with you will be limited and may be made using the information you have provided, including text messages, voicemail, e-mail, letters, etc. If you choose not to be contacted via one of the methods listed above, you must notify Granger Medical in writing. Every effort will be made to respect your request. We DO NOT share your information with third party businesses.

MEDICAL INFORMATION RELEASE TO ASSIGNED PARTIES

In my absence, I authorize Granger Medical to release all or portions of my, or my dependents, medical record(s) to those as indicated below (i.e. lab results, prescriptions, etc.). This authorization is in effect until I revoke it in writing. Please consider others who may bring your children in for care, such as a relative or guardian.

Name:_____ Relationship:_____ Phone:_____

Name:_____ Relationship:_____ Phone:_____

Patient (If 18 years or older) or Parent/Legal Guardian Signature:_____ Date:_____

CREDIT AND FINANCE CHARGE POLICY AND AGREEMENT

I agree to be financially responsible for costs incurred in my, or my dependent's care. I understand that charges for services provided shall be paid for at the time of each visit. If medical claims are submitted to an insurance company by Granger Medical on my behalf, I understand that the copayment or deductible is due at the time care is rendered. I hereby authorize any benefits due me to be paid directly to Granger Medical (assignment of benefits). I understand and agree that I am financially responsible for all deductible amounts, co-insurance, non-covered services or services deemed as "non-medically necessary" by my third party insurance carrier. I agree that I am responsible for satisfying any conditions necessary for insurance or health benefits.

All delinquent accounts will be charged an interest rate of 1.5% per month (18% per annum). In the event any balance is not paid as agreed, the undersigned agrees to pay a collection fee not to exceed 25% of the unpaid balance. In the event of a lawsuit to collect the unpaid balance, the undersigned further agrees to pay court costs and reasonable attorney fees in addition to the collection fee.

You authorize us to call you at any number you provide or at any number at which we reasonably believe we can contact you, including calls and/or text messages to mobile, cellular, or similar devices for any lawful purpose. You agree to any an fee(s) or charge(s) that you may incur for incoming calls and/or text messages from us, and /or outgoing calls to us, to or from any such number, without reimbursement from us.

In consideration for medical services rendered, I (we) acknowledge that I (we) have received notice of Granger Medical's financial policy and agree to pay for said medical services according to such terms.

Patient (If 18 years or older) or Parent/Legal Guardian Signature:_____ Date:_____