Central Wyoming Urological Associates
Helping You With Your Urological Needs

1416 E A Street, Casper, WY 82601
Phone: 307-577-8600 Fax: 307-473-1348

Patient Registration

Is the patient in a hospice program? □ Yes □ No ——— Is the patient residing in a nursing home? □ Yes □ No
If "yes", name and address of facility: _____
Do you have an **Advance Care Plan** or **Surrogate Decision Maker?** □ Yes □ No
If yes, who do we contact to obtain a copy? _____
If not, would you like to discuss establishing one with your provider? □ Yes □ No

Patient Information

First Name _____ MI _____ Last Name _____
Mailing Address _____ City/State/Zip _____
Physical Address (If different) _____ City/State/Zip _____
Home Phone (_____)_____-_____ Work Phone (_____)_____-_____ Cell Phone (_____)_____-_____
If you would like to receive text message appointment reminders or care-related information, text: CWU to 622622
Can we leave a message regarding your medical care & test results on your home phone? □ Yes □ No
Date of Birth _____/_____/_____ Age _____ Social Security Number _____/_____/_____ Gender _____
Ethnicity: □ Non-Hispanic □ Hispanic
Preferred Language: □ English □ Other _____
Race: □ African or African American □ Asian or Asian American □ Caucasian or European American
□ Native American or Native Alaskan □ Native Hawaiian or other Pacific Islander □ Other
Marital Status _____ E-Mail _____
Spouse/Parent Name _____Spouse/Parent Phone Number (_____)_____-_____
May we release medical information to your spouse? □ Yes □ No
Patient Occupation _____ Employer _____
Emergency Contact Person _____Phone Number (_____)_____-_____
Relationship: _____ May we release medical information to your emergency contact? □ Yes □ No
Please list any person(s) with whom we may discuss your medical information: _____

Responsible Party (If different from Patient)

□ Relationship to Patient_____ □ Court Appointed Guardian
First Name _____ MI _____ Last Name _____
Mailing Address _____ City/State/Zip _____
Physical Address (If different) _____ City/State/Zip _____
Home Phone (_____)_____-_____ Work Phone (_____)_____-_____ Cell Phone (_____)_____-_____
Date of Birth _____/_____/_____ Age _____ Social Security Number _____/_____/_____ Gender _____

Medical Information

Referring Physician's Name _____ City/State _____
Primary Care Physician's Name _____ City/State_____
Pharmacy name _____ City/State _____
Workman's Compensation □ No □ Yes — Claim # _____ Date of Injury _____/_____/_____

Turn Over ⇒

Insurance Information and Assignment of Benefits

Primary Insurance Name _____

Insurance Company Address _____

Insurance Company Phone Number _____

Subscribers Name _____Date of Birth _____/_____/_____

Subscribers Social Security Number _____/_____/_____ Relationship to Patient _____

Policy ID # _____ Group # _____

Secondary Insurance Name _____

Insurance Company Address _____

Insurance Company Phone Number _____

Subscribers Name _____Date of Birth _____/_____/_____

Subscribers Social Security Number _____/_____/_____ Relationship to Patient _____

Policy ID # _____ Group # _____

Patient Financial Agreement

In consideration of receiving services from CWUA, you agree:

1. All services are provided to you with the understanding that you are responsible for the cost, regardless of your insurance coverage. If you would like to know the cost of a service, please inquire prior to treatment. Please be aware that not all services are covered benefits with different insurance companies. Telehealth appointments may not be covered benefits through many insurance companies. You are responsible for knowing what services are or are not covered. **KNOW YOUR BENEFITS.**
2. **Upon check-in,** we will collect your deductible, co-pay, and payment for any uncovered services, as well as the patient's portion as determined by insurance. We accept cash, checks, all major credit cards, and Care Credit.
3. Your insurance policy is a contract between you, your employer, and the insurance company! We are NOT a party to that contract.
4. We will bill your insurance company as a courtesy, but you are still ultimately responsible for payment of all services you receive. If your insurance company does not respond within 30 days, we will follow up with an inquiry on your behalf. If, however, your insurance does not respond within 60 days of claim submission, a statement will be sent to you. You should call your insurance to question why the claim is not paid. Our office will assist you only after you have contacted your insurance.
5. Any unpaid charges over 90 days old will be turned over to an outside collection agency with an additional collection agency fee. You are responsible for any collection fees, legal fees, or court costs incurred in the collections process.
   In the event a payment plan is needed, you agree to work with our billing department to set up an acceptable payment plan. Payments will be due promptly each month. In the event the monthly payment is not received as agreed, the entire balance will become due at that time.
6. Returned checks are subject to a $30.00 return check fee. We do understand that temporary financial problems may affect timely payment. We encourage you to communicate any such problems so that we can assist you in the management of your account.
7. I hereby authorize assignment and payment directly to CENTRAL WYOMING UROLOGICAL ASSOCIATES. I HEREBY AGREE TO PAY CO-PAY, COINSURANCE, DEDUCTIBLES, OR ANY AMOUNT NOT COVERED BY INSURANCE. I agree to pay reasonable attorney fees, costs, and collection expenses if the account is turned over to a collection agency.

⇒ **Signature _____ Date _____**

Standard Authorization for Use and Disclosure of PHI and Medical Records

I hereby authorize the disclosure of my PHI (protected health information) to any entity as related to **treatment, payment, or other health care operations, i.e., referring physicians, hospitals, health insurance companies.** The information includes patient demographics, insurance information, and medical records. Some visit notes are created using HIPAA-compliant voice recognition technology.
(You have the right to terminate or revoke authorization by submitting a written revocation to CWUA. Please contact the compliance officer to terminate this authorization. You may request disclosure information from our practice.) HIPAA Disclosure Agreement Provision: **Patients have the right to pay in full for out-of-pocket expenses at the time of healthcare services and request that the practice not disclose their medical information to a health plan or other entity. Please notify the practice of your request.**

⇒ **Signature _____ Date _____**

Acknowledgement of Notice of Our Privacy Practices

I acknowledge receiving the Notice of our Privacy Practices Statement from Central Wyoming Urological Associates, P.C.

⇒ **Signature _____ Date _____**