PATIENT REGISTRATION FORM

DATE _____ ACCT. # (OFFICE USE ONLY) _____

NAME _____
(FIRST) (M.I.) (LAST)

ADDRESS _____

CITY_____ STATE_____ ZIP_____

SEX ☐ M ☐ F D.O.B._____ AGE_____ MARITAL STATUS ☐ S ☐ M ☐ D ☐ W

SOC. SEC #_____ EMAIL _____

PHONE (CHECK PREFERED):

☐ HOME _____ ☐ CELL _____ ☐ WORK _____

OCCUPATION_____ EMPLOYER_____

BUS. ADDRESS_____

EMERGENCY CONTACT _____ RELATIONSHIP_____

TEL: ☐ H ☐ C ☐O _____

WHO REFERRED YOU TO DR. MARANS_____

WHO IS YOUR PRIMARY CARE DOCTOR OR INTERNIST_____

INSURANCE: MEDICARE #: _____ MEDIGAP: _____

INSURANCE CARRIER _____ POLICY # _____ GROUP # _____ COPAY ____

POLICY HOLDER'S NAME IF NOT PATIENT _____

RELATIONSHIP TO YOU _____ DATE OF BIRTH _____

I hereby authorize Hillel Y. Marans, MD to furnish any and all records pertaining to medical history, services rendered or treatment given to me or my dependent for purposes of review, investigation or evaluation of an insurance claim. If I am covered by Medicare, I authorize the release to the Centers for Medicare and Medicaid Services and its agents medical information which is needed to determine Medicare benefits and the benefits payable for related services. I request that payment under Medicare be made directly to Hillel Y. Marans, MD on any services furnished to me by that provider.

I authorize payment direct to Hillel Y. Marans, MD for services rendered. This authorization will remain in effect until it is cancelled by me in writing.

I agree to provide Dr. Marans with any referral authorizations from my primary care physician as required by my managed care insurance provider. I will be financially responsible for services sought without proper authorization.

I understand and agree that practice reserves the right to charge me or give future "standby only" appointments if scheduled appointments are cancelled with less than 24 hours notice.

SIGNATURE _____ DATE _____

*****Fee Schedules and Fee Estimates are Available Upon Request*****

Hillel Y. Marans, M.D., F.A.C.S.
Urology
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Email drmarans@econotek.net

APPOINTMENT CANCELLATION POLICY

Please help us avoid last minute gaps in our schedule!

Please be aware that cancellations with little or no notice disrupt our ability to provide timely medical care to all our patients. In an effort to minimize disruptions caused by appointment cancellations, our office has established the following guidelines:

- If you do not show up for your appointment OR you cancel with less than 24 hours notice, your appointment will be marked as a "No Show."
- Once you have accumulated more than two "No Shows" you will no longer be able to obtain a scheduled appointment. Instead, you will be placed on "Standby" status.
- Once you are on "Standby" status you must call the office on the day you wish to come to find out if there are open slots in the schedule. If there are open slots, you will be given an appointment. If there are none, you will have to call on another day. If you fail to show up for the standby appointment, you will be charged a $100 cancellation fee.
- At any time, if you wish to be removed from "Standby" status so that you can receive a scheduled appointment, you will be charged a $100 cancellation fee.
- If you require urgent care, bring this to the attention of the staff member who is handling your appointment. At the doctor's discretion, you will be given a scheduled appointment.

We ask for your cooperation in giving us timely notice if you have a need to reschedule your appointment.

Signature: _____ Date: _____

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Dear Patient:

We value you as a patient and appreciate that you have entrusted us with your health care needs.

As you know, there are charges for each of the medical care services that we will provide to you. The co-payments, deductibles and co-insurance amounts that we are obligated to collect from you are determined by the type and extent of health benefit coverage that your health benefit plan provides. Our office will be pleased to work with your health benefit plan in verifying your eligibility and benefits and requirements for prior authorizations or referrals. When your health benefit plan pays your claim, they will let you and our office know what your payment obligations are for co-payments, deductibles and coinsurance amounts. It is our policy to obtain your credit card number and authorization so that we may process a claim for these remaining payments which your health benefit plan indicates are your responsibility.

In providing credit card information below, you authorize payment by credit card for services in the absence of coverage by your health benefit plan (including, but not limited to, co-payments, co-insurance, deductibles, and/or uncovered services).

Patient name _____(For Office Use: Account # _____)

Name on Credit Card _____

Card Type: ☐ Visa ☐ Master Card ☐ American Express

Card Number _____ CVV # _____

Expiration date _____ Billing Zip Code _____

Signature _____ Today's date _____