SUMMIT
UROLOGY GROUP

Patient Registration Form (eCW)

PATIENT INFORMATION (Please Print)

☐ Dr. ☐ Miss ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Sir

Patient's Name (Last) ________________________ (First) ____________ (MI) _____ Previous Name ________________________

Address Line 1 ____

City, State ________________________________ ZIP ___________________

Home Phone ______________________ Cell No. ____________________ Work Phone _________________Ext. ___________

Primary Care Physician (PCP) _________________________________ Referring Provider ______________________________

E-Mail Address: ____

Date of Birth MM _______/DD _________/YYYY _____________ Sex ☐ F – Female ☐ M - Male ☐ Transgender

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Legally Separated ☐ Partner

Social Security Number ______-_______-_________

Emergency Contact Last Name ______________________________________ First Name ______________________________

Phone Number ____

Emergency Contact Relationship to Patient ____ ☐ Guardian

PRIMARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Insurance Company/Phone Number____ (_______)_________________

Policy Holder ____ Patient Relationship to Insured______________________

Subscriber ID (Policy Number)___________________ Group ID_________________ Copay Amount_____________________

Effective Date (If Known) _____________________ Date of Birth MM _______/DD _______/YYYY _____

SECONDARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Insurance Company/Phone Number____ (_______)_________________

Policy Holder ____ Patient Relationship to Insured______________________

Subscriber ID (Policy Number)___________________ Group ID_________________ Copay Amount_____________________

Effective Date (If Known) ________________________ Date of Birth MM _______/DD _______/YYYY____

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

Patient (or Responsible Party) Signature____ ***Date***_________________

GRANGER
MEDICAL CLINIC

NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of Summit Urology Group/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 Summit Urology Group/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) / Legal Guardian Signature:____**Date**:_____________________

NOTIFICATION OF APPOINTMENTS/TREATMENT

Summit Urology Group/Granger Medical makes every effort to use your preferred method of communication for appointment/treatment reminders and/or any other issues regarding your account with us. Contact with you may be made using the information you have provided, and may consist of text messages, voicemail, e-mail, letters, etc. If you choose not to be contacted via one of the methods listed above you must notify Summit Urology Group/Granger Medical in writing. Every effort will be made to respect your request.

MEDICAL INFORMATION RELEASE TO ASSIGNED PARTIES

In my absence, I authorize Summit Urology Group/Granger Medical to release all or portions of my, or my dependents, medical record(s) to those as indicated below (i.e. labresults, prescriptions, etc.). This authorization is in effect until I revoke it in writing. (Please consider others who may bring your children in for care, oryour parents, if you are 18 or older). **Please consider Schools and/or Daycare Providers**

Name: ____ Realtionship: _______________________ Phone:___________________

Name: ____ Realtionship: _______________________ Phone:___________________

Patient (If 18 years or older) / Legal Guardian Signature: ____ **Date**:

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 Summit Urology Group/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) / 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 Summit Urology Group/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 Summit Urology Group/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. A finance charge (1.5% per month/APR 18%) will be added to any amount for which payment has not been received within **30 days** from the date of the statement on which the amount first appears. I hereby agree to pay a service charge of $15.00 for each check or other instrument tendered by me but returned to this facility. In the event any amounts are referred to a third party debt collection agency, I agree that in addition to any other amounts allowed by law (interest, court costs, attorney's fees, etc.) I will also be responsible for a collection fee of up to 40% of the principle amount owing as allowed by Utah Code Annotated section 12-1-11. The terms of this paragraph shall apply to all amounts incurred by me or by any individual for whom I have legal responsibility whether such amounts are incurred today or after today.

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

Patient (If 18 years or older) / Legal Guardian Signature:____ **Date**:________________

OFFICE USE ONLY:

Verify ID _________________________________ Type: ____(Driver's License, Passport, etc.)

Employee Signature:____ Date: ___________________________