Alarcon Urology Center

2133 W. Beverly Blvd. Ste. 200 Montebello, CA 90640 (626)284-9278 office (626)284-9746 fax

Patient Registration Form

Date: _____ (Please Print & Complete in Full) **MRN#: _____**

PATIENT INFORMATION

Social Security #: _____-_____-_____

First Name: _____MI: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip: _____ **EMAIL: _____**

Date of Birth: _____/_____/_____ Sex: □ Male □ Female

Marital Status: □ Single □ Married □ Widowed □ Divorced □ Separated

Home Number: (____)_____-_____ Work Number: (____)_____-_____ Cell Number: (____)_____-_____

Race: □ ☐ African American □☐ Asian ☐ Caucasia □ ☐ Hispanic □ ☐ Native American □☐ Other

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino Preferred Language:_____

If Patient is a child, lives with: □ Both Parents □ Mother □ Father □ Other: _____

Name of Person (With Whom Child Lives With): _____

RESPONSIBLE PARTY IF OTHER THAN PATIENT

Social Security #: _____-_____-_____

Responsible Party Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Number: (_____)_____-_____ Work Number: (_____)_____-_____

Date of Birth: _____/_____/_____ Sex: □ Male □ Female Relationship: _____

REFERRED BY:

Referring Physician: _____ Phone:(_____)_____-_____

PCP Physician: _____ Phone:(_____)_____-_____

IN CASE OF EMERGENCY

Relative/Friend: _____ Relationship: _____

Home Number: (_____)_____-_____ Work Number: (_____)_____-_____

PHARMACY INFORMATION

Pharmacy Name: _____

(Name, Street Name & Phone Number, if known)

The above information is true to the best of my knowledge. Professional fees are due at the time services are rendered. These include but not limited to co-pays, deductibles, self pay and all discount plan payments. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for all balances that are not covered by my insurance plan. I also authorize Alarcon Urology Center and the insurance company to release any information required to process my claims. If it becomes necessary to collect fees through the services of an attorney or collection agency, I understand this will increase my balance approximately 30%.

PATIENT SIGNATURE: _____ DATE: _____

ALARCON UROLOGY CENTER

HIPPA NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or healthcare operation (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you including demographic information that may identify you and that relates to your past, present and future physical or mental health or condition and related to health care services.

Uses and Disclosure of Protected Health Information: Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, a necessary, to a home health agency that provides care to you. For example your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that you relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operation: We may use or disclose, as needed, your protected health information in order to support business activities of your physician's practice. These activities include, but are not limited to support the business activities of your physician's practice. These activities include, but are not limited to quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

ALARCON UROLOGY CENTER

PF-3000(b) NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

We keep a record of health care service we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting your office's Practice Administrator.

Our Note of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information.

By signature below, I authorize receipt of the Notice of Privacy Practices.

_____ _____

PRINT PATIENT'S NAME **PATIENT'S MRN NUMBER**

_____ _____

Patient or Legally authorized individual signature Date & Time

_____ _____

Printed Name if signed on behalf of the patient Relationship to Patient

AUTHORIZATION FOR PERSONS TO WHOM INFORMATION MAY BE DISCLOSED:

_____ _____

Print Name of person/organization Relationship of Patient

_____ _____

Print Name of person/organization Relationship of Patient

ALARCON UROLOGY CENTER

RECORDS RELEASE FORM

From: _____

Address: _____

I hereby authorize and request the release of copies of the following information

Complete Laboratory Records

Medical Record Procedure Reports

X-Rays Other_____

INCLUDNG CURRENT AND PREVIOUS MEDICAL RECORDS FROM OTHER PRACTICES AND PRACTITIONERS, HOSPITALS AND/OR CLINIC WHICH ARE A PART OF MY MEDICAL RECORDS.

To: _____

Address:_____

This information has been released to you specifically with the consent of the patient or his/her authorized representative. It is strictly confidential and no further release or use of the information is authorized without the consent of the patient or authorized representative. I hereby release the facility from any Liability, which may arise as a result of the use of the information contained in the records released.

Patient Name: _____ Date of Birth:_____

Social Security #_____ Phone# _____

Signature:_____ Date: _____

Single disclosure Continuing disclosure for 90 days Expiration Date:

I hereby release the facility from any Liability, which may arise as a result of the use of the information contained in the records released.

ALARCON UROLOGY CENTER

FINANCIAL RESPONSIBILITY

Patient Name: _____

MRN# _____

Date: _____

I understand that I am financially responsible to J. Antonio Alarcon M.D., Inc. for charges not covered by my insurance carrier. Payment for services is due at time of service unless prior arrangements have been made. I also agree that, should I fail to assume that financial responsibility and credit action is necessary, I will pay for these costs in addition to the amount of the doctor's charges. I authorize J. Antonio Alarcon M.D., Inc. to release to the Social Security Administration or its intermediaries or carriers, or other insurance carriers any medical or other information needed for this or related insurance claim. A copy of the authorization may be used in place of the original.

I understand if I have an unpaid balance to Alarcon Urology Center and do not make satisfactory payment arrangements, my account may be placed with an external collection agency. I will be responsible for reimbursement of any fees from the collection agency, including all costs and expenses incurred collecting my account, and possibly including reasonable attorney's fees if so incurred during collection efforts.

In order for Alarcon Urology Center or their designated external collection agency to service my account, and where not prohibited by applicable law, I agree that Alarcon Urology Center and the designated external collection agency are authorized to (i) contact me by telephone at the telephone number(s) I am providing, including wireless telephone numbers, which could result in charges to me, (ii) contact me by sending text messages (message and data rates may apply) or emails, using any email address I provide and (iii) methods of contact may include using pre-recorded/artificial voice message and/or use of an automatic dialing device, as applicable.

_____ _____

Signature of Patient or Guardian Date

ALARCON UROLOGY CENTER

CANCELLATION POLICY

We strive to create as many appointments as possible for our physician and nurses to provide all the services needed by our patients. We need your help to make this system work well for all concerned. We know and understand how busy your lives are and know plans change. We would like the simple courtesy of a phone call if an appointment cannot be kept so that we may accommodate another patient.

It is our policy that any prescheduled appointment be cancelled at least 24 hours in advance except in the case of an extreme emergency.

If an appointment is cancelled, we will do our best to give you the next available appointment time for the type of visit required. Since we reserved this time for you, we are unable to offer it, to any other patient who may need an appointment. **If you do not keep your appointment and do not cancel at least 24 hours in advance you will be charged $20.00 for an office visit, $50.00 for a procedure/test and $100.00 for surgery.**

We appreciate your understanding and cooperation with this new policy.
J. Antonio Alarcon, M.D.

Signature and Date _____