CWUA
Central Wyoming
Urological Association

Patient Registration

1416 E. A St. Suite 101
Casper, WY 82601
Ph: (307) 577-8600

IS THE PATIENT RESIDING IN A NURSING HOME FACILITY? 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 No, Would you like to talk to your provider about establishing one? YES NO

Patient Information

First Name _____ Middle Initial ____ Last Name _____

Mailing Address _____ City/State/Zip _____

Home Phone _____Work Phone _____Cell Phone _____

If you would like to receive text message appt. 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 _____

Relationship to patient _____ Phone Number _____

May we release medical information to your emergency contact person? ☐ Yes ☐ No

Please list any person(s) with whom we may discuss your medical information: _____

☐ **Responsible Party (if different from patient)** ☐ **Court Appointed Guardian**

First Name _____ Middle Initial ____ Last Name _____

Mailing Address _____ City/State/Zip _____

Home Phone _____Work Phone _____Cell Phone _____

Date of Birth ____/____/____ Social Security Number ____/____/____ Gender _____

Relationship to patient _____

Medical Information

Referring Physician's Name _____ City/State _____

Primary Care Physician's Name _____ City/State_____

Pharmacy name _____

Workman's Compensation ☐ Yes ☐No Claim # _____ Date of Injury _____

Turn Over ⇒

CWUA
Central Wyoming
Urological Association

1416 E. A St. Suite 101
Casper, WY 82601
Ph: (307) 577-8600

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 _____
Policy ID # _____ Group # _____
Relationship to Patient _____

Secondary Insurance Name _____
Insurance Company Address _____
Insurance Company Phone Number _____
Subscribers Name _____ Date of Birth ___/___/____
Subscribers Social Security Number _____
Policy ID # _____ Group # _____
Relationship to Patient _____

Assignment of Benefits

I hereby authorize assignment and payment directly to CENTRAL WYOMING UROLOGICAL ASSOCTIATES. I HEREBY AGREE TO PAY COPAY, COINSURANCE, DEDUCTIBLES, OR ANY AMOUNT NOT COVERED BY INSURANCE. I agree to pay reasonable attorney fees, costs and collection expenses if account is turned 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.

⇒ **Signature _____ Date _____**

(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 your medical information to a health plan or other entity. Please notify the practice of your request.**

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 _____**