STARKVILLE
UROLOGY

GORDON M. CASTLEBERRY, M.D.
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STARKVILLE, MS 39759
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NEW PATIENT INFORMATION

Date:

Legal Name:

Last | First | Middle Initial

How do you wish to be addressed?

Email Address:

Address:

Number | Street | Apt# | City | State | Zip Code

Home Telephone# Alternate Telephone #

Date of Birth: Social Security # Sex: Male Female

Referred by: Marital Status: (circle one) S M D W Sep

RESPONSIBLE PARTY (IF DIFFERENT FROM ABOVE)

Legal Name:

Last | First | Middle Initial

Relationship to Patient:

Address:

Number | Street | Apt# | City | State | Zip Code

Home Telephone# Alternate Telephone #

Date of Birth: Social Security # Sex: Male Female

EMPLOYER INFORMATION

Occupation:

Employer Name | Address | Telephone #

FAMILY PHYSICIAN AND PHARMACY

Physician's Name | Address | Telephone #

Pharmacy's Name | Address | Telephone #

INSURANCE NAME (PRIMARY)	INSURANCE NAME (SECONDARY)
Subscriber Name	Subscriber Name
Name of Insurance	Name of Insurance
Identification # Date of Birth	Identification # Date of Birth
Group Name or Number	Group Name or Number
Relationship to Insured	Relationship to Insured

NEW PATIENT INFORMATION

CONFIDENTIAL COMMUNICATIONS PREFERENCE

You may request confidential communications of Protected Health Information in the method you prefer or at at alternative address. For example, you may not want your appointment or billing statement to be mailed to your home where it may seen by others.

Please select all that applies and sign below:

PROTECTED HEALTH INFORMATION

I Laboratory, X-ray, test results, billing statements, and/or any correspondence pertaining to Protected Health Information; I authorize Dr. Castleberry or the staff members to leave message or mail results unless the following is marked:

☐ DO NOT LEAVE A MESSAGE OTHER THAN TO RETURN THE CALL

☐ DO NOT MAIL RESULTS

II **Authorized Person(s): Person who can receive Protected Health Information.**

Y N Other person(s) authorized: _____

_____

_____

_____

_____

_____

Full Name | Telephone # | Relationship

III **Billing Statements and Correspondence:**

Any correspondence related to your health information will be automatically mailed to your home address, unless other address is given below:

_____

Address | City | State | Zip Code

IIII **Prescription History Release:**

I agree that Starkville Urology may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes unless the following is marked: ☐ **NOT AUTHORIZED**

Medical Treatment Consent & Right to Terminate or Revoke Authorization:

This authorization is for medical treatment and effective through indefinitly until revoked or terminated by Patient or Patient's personal representative by a written revocation to Starkville Urology.

_____

PATIENT SIGNATURE (or Legal Representative) | Date

Relationship, if Legal Representative: _____

Thank you for assisting us to serve you more effectively.

NEW PATIENT INFORMATION

ASSIGNMENT OF BENEFITS

I hereby assign medical and/or surgical payments including major medical benefits to which I am entitled, private insurance and any other health plan to Starkville Urology, A Medical Corporation for services provided by Starkville Urology. This assignment will remain in effect until revoked by me in writing.

A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurances.
I hereby authorize said assignee to release all information to secure the payment

PRIVACY PRACTICES ACKNOWLEDGEMENT

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. You are provided a hard copy of this notice for you to have and we have also provided a laminated copy in our waiting room. Please review it carefully.

FINANCIAL POLICY

PAST DUE ACCOUNTS

If your account balance becomes 180 days past due and you haven't made any arrangements, we will report your account information to the credit bureau. This will give us access to your credit history and affect your credit in a negative way.

INSURANCE - CASH PATIENTS

Patients are financially responsible for services provided and are expected to pay at the time of service. As a courtesy, we will bill your insurance, however, you will need to provide complete billing information at the time of your visit. A copy of your charges, if requested, will be supplied to you so that you may follow up with your insurance company personally.

HMO - PPO PATIENTS

If you are a member of an HMO/PPO, you are required by your health plan to pay a co-payment at the time of your visit. We cannot waive the co-payment amount as a contracted provider. Co-payments will be collected at the time of service. Non-covered services must be paid at the time of the service.

MEDICARE

We are Participating Providers in Medicare, which means that we accept Medicare assignment as payment in full, once your deductible and co-payments have been made. We will bill Medicare for you, as well as your supplemental insurance. You must provide us with valid cards from Medicare and other insurance. Without these documents we cannot bill your insurance and payment will be expected from you at the time of your visit. Deductibles will be paid at the time of service.

RELEASE OF INFORMATION

I hereby authorize the release of medical information to insurance carriers concerning my illness and treatment and I hereby assign to the doctor all payments for medical services rendered to my dependent. I understand I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE.

ACCOUNT BALANCE & PAYMENT PLANS

As of 2017, we have a new policy regarding balances on patient's accounts. If a balance is under $500, you have the option to pay it off in full or pay in 6 monthly installments. If a balance is over $500, you have the option to pay it off in full or pay in 12 monthly installments.

Signed: **Date:**