UROLOGY ASSOCIATES, PC

Date:_____/_____/_____

PATIENT REGISTRATION FORM

Please Print and Complete in Full

Account Number (office staff will complete): _____

PATIENT INFORMATION

Social Security #:_____-_____-_____ Date of Birth:_____ Age:_____

Last Name: _____ First Name:_____ Middle: _____

Address: _____

City: _____ State: _____ Zip: _____

Cell Phone: (_____) _____-_____ Work Phone: (_____) _____-_____

Home Phone: (_____) _____-_____ Sex: (circle) Female or Male

E-mail Address: _____

Marital Status: (circle) Single Married Widowed Divorced Separated

Race: (circle) African American Asian Caucasian Hispanic Native American Other

Ethnicity: (circle) Hispanic Non-Hispanic

Preferred Language: _____

EMPLOYER INFORMATION

Employed: Y or N Full-time Student ____ Part-time Student ____

Employer Name: _____

Main Office Phone: (_____) _____-_____ Occupation:_____

INSURANCE INFORMATION (We Require a Copy of Your Card)

Primary Insurance:_____

Policy Holder Name (If other than yourself): _____ Relationship: _____

Policy Holder Employer:_____

Policy Holder Social Security #:_____-_____-_____ Date of Birth: _____

Secondary Insurance:_____

REFERRED BY

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

PRIMARY CARE PHYSICIAN

Primary Care Physician:_____ Phone: (_____) _____-_____

EMERGENCY CONTACT

Name:_____ Relationship:_____

Cell Phone: (_____) _____-_____ Work Phone: (_____) _____-_____

PATIENT NAME:_____ DATE:_____

Which physician are you seeing today?_____ Account #:_____

SIGNATURE FORM

FINANCIAL RESPONSIBILITY, RELEASE INFORMATION, AND NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that I am financially responsible to Urology Associates, P.C. 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 this 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 Urology Associates, P.C. to release to the Social Security Administration or its intermediaries or carriers, or other insurance carrier any medical or other information needed for this or a related insurance claim. A copy of this authorization may be used in place of the original.

Pf-3000 (b) NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

We keep a record of the health care services 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 the practice Administrator.

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

By my signature below I acknowledge that I have read and understand the Urology Associates, P.C. Billing Policies as well as my financial responsibility, and I acknowledge receipt of the Notice of Privacy Practices.

Signature of Patient or Guardian:_____ Date:_____

AUTHORIZATION FOR PERSONS TO WHOM INFORMATION MAY BE DISCLOSED:

_____ _____

Print name of person / organization Relationship to Patient

_____ _____

Print name of person / organization Relationship to Patient

Please continue only if you have Medicare and/or Medicaid.

EXTENDED PAYMENT REQUEST (ONE TIME AUTHORIZATION)

I request that payment of authorized Medicare benefits or other insurance benefits (including Medigap benefits) be made on my behalf to Urology Associates, P.C. for any services furnished to me by that provider. This one time signature will be maintained on file as verification for all subsequent services which are provided to you by this provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents or other insurance carriers any information needed to determine these benefits or the benefits payable for related services. I authorize any holder of medical information about me to release to the Medigap Insurer (if applicable) any information needed to determine these benefits or the benefits payable for related services.

Signature of Patient or Guardian:_____ Date:_____

BILLING POLICY

Thank you for choosing Urology Associates, P.C. as your healthcare provider. Our providers and staff are committed to delivering service, compassion, and quality care to you. Understanding our Financial Policy is an important part of our professional relationship.

Financial Policy

Your insurance co-payment*is due at the time of your visit. If you are unable to pay your co-payment at the time of your visit, we will reschedule your visit.

If we determine you have a deductible* or co-insurance* amount due, you will be asked to pay this amount at the time of your visit.

If you are required to obtain a referral from your primary care physician in order to see a urologist, it is your responsibility to bring this with you to your visit. If you do not have a referral, we will reschedule your visit so you can obtain one.

Urology Associates will assist in obtaining pre-certification from insurance plans if required. However, insurances vary in coverage, and it is the patient's responsibility to understand medical benefits and requirements. We recommend that the patient verifies insurance benefits for any procedures, test, or services scheduled.

It is your responsibility to know if we participate with your insurance plan. If your insurance company is out of network with us, you will be responsible for payment in full at the time of service.

You will be responsible for 100% of your total out of pocket* responsibility amount prior to any procedures, testing, or services.

For self-pay patients, $150.00 deposit is due at check-in. A credit card on file is required for the remaining balance which is expected to be paid in full at check-out.

We do our best to estimate your financial responsibility up front, but please understand this is only an estimate.

Cancellation/No-Show/Reschedule Policy

In order to provide the best care and service to our patients, we ask that you notify us 24 hours in advance to cancel and/or reschedule your office appointment. If you forget or fail to show up for the appointment, there will be a $50.00 fee charged to your account.

Cancellation of a scheduled procedure, surgery or diagnostic imaging requires 72 hours' notice. Any cancellation not made 72 hours in advance will be subject to a fee of $150.00.

Cancellation of a scheduled PET CT scan requires 72 hours' notice. Any cancellation not made 72 hours in advance will be subject to a fee of $500.00.

A $150.00 deposit is required at the time of scheduling a Vasectomy. The deposit will apply to the balance of your procedure. Cancellation of a scheduled Vasectomy requires 72 hours' notice. Any cancellation not made 72 hours in advance will result in forfeiture of the $150.00 deposit, and you will be required to pay an additional deposit at the time of rescheduling.

A reschedule fee of $75.00 will be charged each time a procedure or surgery appointment is rescheduled.

The Cancellation/No-Show/Reschedule fees will not be billed to insurance.

Signature of Patient or Guardian:_____ Date:_____

Helpful Definitions

Out of pocket: Costs you have to pay yourself.
Copayment (or copay): Fixed amount you pay at each visit for services such as an office visit. (You pay your copay at the time of service, even if you have met your deductible, until you meet your out-of-pocket maximum.)
Deductible: The yearly amount you must pay before your insurance begins to pay.
Coinsurance: The percentage you pay for care even after your deductible is paid in full.
Out-of-pocket maximum: The most money you will pay in one year for all covered services. This usually includes all out-of-pocket costs: copayments, deductibles, and coinsurance.

UROLOGY ASSOCIATES – Patient History Form

MRN:_____ **PROVIDER:**_____

NAME:_____ **DATE:** _____/_____/_____
DOB: _____/_____/_____ **AGE:**_____ **SEX:** M / F
Primary Care Physician (Name, Address, Phone): _____
Who referred you to our Practice?_____ **Pharmacy Name & Location:** _____
Have you ever undergone a surgical procedure: □ No □ Yes If yes, please list any surgeries with dates: _____
_____

I have a <u>personal</u> history of: *please circle all that apply*
Cancer (type):_____
Cataract Diabetes Glaucoma Heart Disease High Blood Pressure Kidney Disease Seizures Stomach Ulcers Stroke

I have a <u>family</u> history of: *please circle all that apply*
Breast Cancer Ovarian Cancer Pancreatic Cancer Prostate Cancer Other Cancer (type):_____
Cataract Diabetes Glaucoma Heart Disease High Blood Pressure Kidney Disease Seizures Stomach Ulcers Stroke

What is your marital status? □ Single □ Married □ Separated □ Divorced □ Widowed

Number of Children:_____ What is your occupation? _____
Do you currently use tobacco? □ No □ Yes If yes, type of tobacco used and frequency?_____
Do you have a history of Tobacco Use? □ No □ Yes If yes, type of tobacco used and frequency?_____
Do you have a history of drug abuse? □ No □ Yes
Is there any caffeine use? □ No □ Yes If yes, (*circle*) Coffee Tea Soda Servings per day:_____
Do you drink alcohol? □ No □ Yes If yes, how often? Occasionally Moderately Heavily Type? Beer Wine Liquor

FOR FEMALE PATIENTS ONLY:
Do you have menstrual periods? □ No □ Yes If yes, date of last period? _____/_____/_____
Are your periods regular? □ No □ Yes Is there a chance you may be pregnant? □ No □ Yes

Have you had a colonoscopy this year? □ No □ Yes
Have you had a flu shot this year? □ No □ Yes

How would you feel if you had to live with your current urological problem the way it is now, no better, no worse, for the rest of your life? (Please circle the number that best reflects your feelings about the current problem we are seeing you for today.)

Delighted	Pleased	Mostly satisfied	Mixed	Mostly dissatisfied	Unhappy	Terrible
						
0	1	2	3	4	5	6

Would you be interested in learning about other treatment options that may allow you to discontinue your urology medication(s)? □No□Yes

Do you have any sexual problems? □ No □ Yes

Are you currently experiencing any of the following? (please circle all that apply) **NONE**

General: Chills Fever Tiredness
Skin: Lesions Rash
HEENT: Blurred vision Cataract Glaucoma Ear Infection Seasonal Allergies Bleeding Gums Sore Throat
Neck: Swollen glands
Respiratory: Difficulty Breathing
Cardiovascular: Chest pain High Blood Pressure Shortness of breath
Gastrointestinal: Abdominal pain Constipation Nausea Vomiting
Genitourinary: Blood in urine Frequency Uncontrolled loss of urine
Musculoskeletal: Back Pain
Neurological: Dizziness Numbness Headaches
Psychiatric: Anxiety Depression Overly Stressed Psychological Problems
Endocrine: Excessive Thirst Hepatitis Sexual Dysfunction
Hematology: Easy Bleeding Easy Bruising Swollen Lymph Nodes

PATIENT MEDICATION LIST

PATIENT NAME		PHYSICIAN
DATE	DOB	MRN

PRESCRIPTION MEDICATIONS

MEDICATION	DOSAGE	DIRECTIONS

OVER THE COUNTER MEDICATIONS: Aspirin, Vitamins, Diet Pills, etc.

MEDICATION	DOSAGE	DIRECTIONS

CURRENT ALLERGIES: MEDICATIONS, FOODS, PRODUCTS
