Urologic Patient Information Form

Patient Information Med Rec #______________________

Legal Name ____ Date of Birth ____________________
(Last) (First) (Middle)
Mailing Address ____
Physical Address (if different from mailing) ____
Home Phone _______________________ Cell Phone _______________________ Work Phone ______________________
Social Security # _________________________ Sex: M / F Marital Status: S / M / D / W
Employer _____________________________________ Employer Address: _____________________________________
Spouse ____ Spouse Soc Sec # ___________________________
If a physician or other medical provider referred you, who referred you ____

Race (circle one): American Indian or Alaskan Native / Asian / Black or African American /
Native Hawaiian or other Pacific Islander / White
Ethnicity (circle one): Hispanic / Non Hispanic
Preferred Language (circle one if preferred): English / Spanish / Other ______________________________
Email address: ____
Preferred Method of contact (circle one): Phone – Home or Cell / Mail / Email
Preferred Pharmacy/Location ____

Parent or other Responsible Party if other than patient
Legal Name ____ Date of Birth ____________________
(Last) (First) (Middle)
Mailing Address ____
Home Phone _______________________ Cell Phone _______________________ Work Phone ______________________
Social Security # _________________________ Sex: M / F Marital Status: S / M / D / W
Employer ____ City _________________________________

Insured Information if Insured is Not Patient nor Responsible Party
Insured's Name ____ Date of Birth ____________________________
Insured's Social Security #______________________________________
Insured's Phone Number ____________________________________ Employer___________________________________

Notice of Privacy Practices
I acknowledge I have been offered a copy of Urologic's Notice of Privacy Practices:
Signature ____

Emergency Contact Information

Name _____________________________________ Phone number(s) ____

Telephone Consent
I understand the Clinic or its agents may use prerecorded/artificial voice messages and/or auto dialing devices to remind me about appointments or notify be of other information and I expressly consent to the Clinic or its agents use of any number associated with my account, including wireless numbers, including contact done by prerecorded/artificial voice messages and/or automatic dialing devices, for the purposes of collecting on my account.

Signature ____ Date _____________________________

Urologic Financial Policy / Consent to Treat

Med Rec #____________________

You must pay your copay and any coinsurance at each visit. You must pay any deductible or coinsurance BEFORE any office procedure, CT or surgery is performed.

Financial Responsibility
Urologic (Clinic) participates in the Medicare and Mississippi Medicaid programs as well as other commercial insurance products. We do not participate in some HMO plans. If the Clinic participates in your insurance plan you will be responsible for all copays, deductibles, and coinsurance amounts at the time of service. You will also be responsible for any services not covered by your insurance plan. **You must bring your insurance card(s) to every visit.**

If the Clinic does not participate in your insurance, you will be considered Self Pay. You will be required to pay a $200 deposit on your first visit which will be applied to your charges. If you have any questions regarding the networks we participate in, please ask prior to being seen.

If you do not have any insurance, you will be **required to pay a $200 deposit** on your first visit which will be applied against your charges. **This must be paid before you are seen.** All future charges should be paid at time of service unless you work out other payment arrangements with our billing staff. We do offer patients with no insurance coverage a discount when charges are paid in full at time of service. Please ask any of our billing or check out staff about this discount.

You understand that you are financially responsible for all Clinic charges unless covered and paid by your third-party insurance as explained above. If you should default on your financial responsibility, you understand that your account may be turned over to a collection agency. If this occurs, you may be charged for all reasonable collection fees incurred by the Clinic. You consent to receive communications regarding your account from the Clinic or its collectors by any phone number(s) you provide including cell, employer, and home landline numbers.

The Clinic reserves the right to charge patients a $25.00 fee for no-show/cancellation (less than 24 hours' notice), medical records, FMLA, etc.

Assignment of Benefits
Medicare and Medicaid: You hereby request that payment of authorized Medicare/Medicaid benefits for services rendered by the Clinic on your behalf, shall be made to the Clinic, and you specifically assign such benefits to the Clinic. You hereby certify that all information given by you in connection with applying for such benefits is correct and complete in all respects. You understand that payment for certain services not deemed medically necessary by Medicare/Medicaid are not authorized under the Medicare/Medicaid Programs to pay any and all copays, coinsurance, and deductibles upon demand by the Clinic, including at the time of service.
Commercial Insurance: You hereby assign to the Clinic all rights, benefits and interest under any insurance policy, health plan, or workers compensation plan in consideration for services rendered by the Clinic. You hereby authorize payment of such benefits directly to the Clinic for treatment you receive by the Clinic. You understand that you are required to pay any and all copays, coinsurance, and deductibles upon demand by the Clinic, including at the time of service.

DISCLAIMER: Urologic utilizes an independent lab, PathGroup, for lab services/pathology. The billing is independent of Urologic. It is your responsibility to determine whether PathGroup is in-network with your insurance.

Consent to Release Health Information for Billing and Payment Purposes
You hereby consent to the release of your health information by the Clinic for the purpose of obtaining authorization and payment of services rendered to you by the Clinic. Your consent does NOT waive your privacy rights under federal law (known as the Health Insurance Portability and Accountability Act, or HIPAA).

"I understand that payment is due at the time of service. I agree to pay collection fees of 25% of the unpaid balance at such time that my account is placed with a collection agency. I further agree that I am responsible for all costs associated with the collection of my account, including but not limited to postage costs, and all credit card processing costs. In the event my account is referred to an attorney for collection, I agree to be liable for attorney's fees of 33% of the unpaid balance, and all costs of court. I also authorize my employment location and status to be verified for the purpose of processing my bill for payment. I authorize the use of the phone number and other contact information I provide, including cellular number and any future numbers assigned to me, for calls, texts, emails, to include automated dialers, to contact me regarding my care and my account by the medical provider and this medical providers' business associates."

____ _______________________

Patient or Responsible Party Signature Date

Release of Medical Information

I authorize the staff at Urologic to discuss my medical information with the following persons. This authorization shall remain in effect until such time as it is withdrawn by me in writing.

___________________________________ Relationship ________________________ Phone ______________________

___________________________________ Relationship ________________________ Phone ______________________

___________________________________ Relationship ________________________ Phone ______________________

___________________________________ Relationship ________________________ Phone ______________________

Signature ____ Date _____________________________

PATIENT HISTORY FORM

NOTE: THIS IS A CONFIDENTIAL RECORD AND WILL BE KEPT IN YOUR DOCTOR'S OFFICE. INFORMATION CONTAINED HERIN WILL NOT BE RELEASED TO ANYONE WITHOUT YOUR AUTHORIZATION TO DO SO.

TODAY'S DATE: ____________ DATE OF LAST PHYSICAL EXAM: ____________

LAST NAME:_________________________ FIRST NAME:_____________________ MIDDLE INITIAL:_____

SOCIAL SECURITY NO:_______________ DATE OF BIRTH:___________________ PHONE NO:____________________

PHARMACY NAME: ___________________ PHARMACY LOCATION: _______________________REFERRING DOCTOR:_____________________

WHAT IS THE MAIN REASON FOR YOUR VISIT TODAY? (DESCRIBE YOUR PROBLEM IN DETAIL)

____

____

____

PHYSICIAN USE ONLY (COMMENTS/NOTES)

# ANSWERS	LEVEL OF SERVICE
1-3	1 OR 2
4+	3 - 5

<u>FAMILY HISTORY</u>

LIST ALL SERIOUS ILLNESSES (DIABETES, TUBERCULOSIS, BREAST CANCER, HEART DISEASE, ETC) IN YOUR <u>IMMEDIATE</u> FAMILY

____ ____

____ ____

____ ____

LIST ANY PERSONAL PAST ILLNESS AND/OR SURGERIES AND WHEN THEY OCCURRED

<u>ILLNESS OR SURGERY</u>	<u>DATE</u>
______________________	_____________
______________________	_____________
______________________	_____________
______________________	_____________
______________________	_____________
______________________	_____________
______________________	_____________

ARE YOU ON ANY MEDICATIONS? Y N (IF YES, LIST ALL)

____________________ ____________________

____________________ ____________________

____________________ ____________________

____________________ ____________________

____________________ ____________________

____________________ ____________________

ARE YOU ON A SPECIAL DIET? Y N (IF YES, PLEASE EXPLAIN)

____

ARE YOU ALLERGIC TO ANY MEDICATIONS? Y N

IF SO, PLEASE LIST BELOW:

____________________ ____________________

____________________ ____________________

____________________ ____________________

____________________ ____________________

DO YOU SMOKE? Y N

(IF YES, PLEASE LIST BELOW)

IF YES, HOW MUCH? _________________

DO YOU DRINK ALCOHOL? Y N

IF YES, HOW MUCH? __________________

DO YOU DRINK COFFEE? Y N

IF YES, HOW MUCH? __________________

DO YOU DRINK TEA? Y N

IF YES, HOW MUCH? __________________

DO YOU EAT CHOCOLATE? Y N

IF YES, HOW MUCH? __________________

DO YOU DRINK SOFT DRINKS? Y N

IF YES, HOW MUCH? __________________

PHYSICIAN USE ONLY (COMMENTS/NOTES)

# ANSWERS	LEVEL OF SERVICE
0	1 OR 2
1 – 2	3
3	4 OR 5

REVIEW OF SYSTEMS

DO YOU NOW OR HAVE YOU HAD ANY PROBLEMS IN THE PAST 2 WEEKS RELATED TO THE FOLLOWING SYTEMS? CIRCLE YES OR NO. PLEASE EXPLAIN ANY YES ANSWERS IN THE SPACE PROVIDED.

CONSTITUTIONAL SYMPTOMS

FEVER Y N
CHILLS Y N
HEADACHE Y N
OTHER _________________

EYES

BLURRED VISION Y N
DOUBLE VISION Y N
PAIN Y N
OTHER ____________________

ALLERGIC/IMMUNOLOGIC

HAY FEVER Y N
DRUG ALLERGIES Y N
OTHER ____________________

NEUROLOGICAL

TREMORS Y N
DIZZY SPELLS Y N
NUMBNESS/TINGLING Y N
OTHER _________________

ENDOCRINE

EXCESSIVE THIRST Y N
TOO HOT/COLD Y N
TIRED/SLUGGISH Y N
OTHER _________________

GASTROINTESTINAL

ABDOMINAL PAIN Y N
NAUSEA/VOMITING Y N
INDIGESTION/HEARTBURN Y N
OTHER _________________

CARDIOVASCULAR

CHEST PAIN Y N
VARICOSE VEINS Y N
HIGH BLOOD PRESSURE Y N
OTHER _________________

INTEGUMENTARY

SKIN RASH Y N
BOILS Y N
PERSISTENT ITCH Y N
OTHER ___________________

MUSCULOSKELETAL

JOINT PAIN Y N
NECK PAIN Y N
BACK PAIN Y N
OTHER ___________________

EAR/NOSE/THROAT/MOUTH

EAR INFECTION Y N
SORE THROAT Y N
SINUS PROBLEMSY N
OTHER ___________________

GENITOURINARY

URINE RETENTION Y N
PAINFUL URINATION Y N
URINARY FREQUENCY Y N
OTHER __________________

RESPIRATORY

WHEEZING Y N
FREQUENT COUGH Y N
SHORTNESS OF BREATH Y N
OTHER __________________

HEMATOLOGIC/LYMPHATIC

SWOLLEN GLANDS Y N
BLOOD CLOTTING PROBLEM Y N
OTHER __________________

PHYSICIAN USE ONLY (COMMENTS/NOTES)

PHYSICIAN: ____ DATE: _____________________________