



Patient Name: _____ Date: _____

Name Prefer to be Called: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Sex: _____ Date of Birth: _____ Age: _____ Race: _____

Phone-Home: _____ Phone-Work: _____ Ext: _____ Phone-Cell: _____

E-Mail: _____ Fax Number: _____

Social Security Number: _____ Employer: _____

Primary Care Physician: _____ Referring Physician: _____

Marital Status: _____ Spouse's Name: _____ DOB: ____ - ____ - ____

Emergency Contact: _____ Relationship: _____

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

Who referred you to our practice?

- Relative/Friend Insurance Company Yellow Pages Website Other
Hospital/ER Health Screening Pharmacy Billboard Ledger or Bayonet
TV Radio Magazine Newspaper
Facebook Seminar Internet Physician

INSURANCE PLAN INFORMATION

Primary Insurance Plan: Effective Date: Copay:
Policy Number: Group Number: Referral Required: yes no
Primary Insured's Name: Primary Insured's Date of Birth:

Secondary Insurance Plan: Effective Date: Copay:
Policy Number: Group Number: Referral Required: yes no
Primary Insured's Name: Primary Insured's Date of Birth:

Tertiary Insurance Plan: Effective Date:
Policy Number: Group Number: Referral Required: yes no
Primary Insured's Name: Primary Insured's Date of Birth:

I understand that if my insurance company requires a referral form, it is my responsibility, as the patient, to get a referral form from my primary care physician. I understand that I am responsible for the charges for medical services rendered. I have been presented with a copy of the notice of privacy practices, detailing how my health information may be used and disclosed as permitted under federal and state law, and outlining my rights regarding my health information. I request that payment of authorized benefits be made on my behalf to the above provider for services rendered. I authorize release to the indicated insurance carrier any medical information about me needed to determine these payments for related services.

Signature: _____ Date: ____ - ____ - ____

FINANCIAL POLICY

This is an agreement between Urology Center of Columbus, LLC and the patient or responsible party named on this form.

In this agreement the word “you” and “your” means the patient or responsible party. The word “account” means the account that has been established in your name to which charges are made and payments credited. The words “we”, “us” and “our” refer to Urology Center of Columbus, LLC.

By executing this agreement, you are agreeing to pay for all services that are received.

Monthly Statement: If you have a balance on your account, we will send you a monthly statement. It will show separately the previous balance, any new charges to the account, the finance charge, if any, and any payments or credits applied to your account during the month.

Payments: Unless other arrangements are approved by us in writing, the balance on your statement is due and payable when the statement is issued and is past due if not paid by the end of the month.

Charges to Account: We shall have the right to cancel your privilege to make charges against your account at any time. Future visits would then need to be paid at time of service.

Required Payments: Any co-payments required by an insurance company must be paid at the time of service. This is an insurance requirement. Your insurance plan requires that you pay a deductible and out of pocket every year. You will be required to pay any balance remaining on your deductible at the time of service unless arrangements are made with our billing department in advance.

Payment Options: You may pay for service rendered by cash, personal check, money order or credit card. We also offer several options for financing your account with lending institutions and will assist you in this process. We understand that we all sometimes have difficult times and extenuating circumstances and we will make every effort to work with you to our mutual benefit but we ask that you notify our billing department of such case in advance.

Contracted Insurance: (In Network): If we are contracted with your insurance company, we must follow our contract and their requirements. If you have a co-pay or deductible, you must pay that at the time of service. It is the insurance company that makes the final determination of your eligibility. If your insurance company requires a referral and / or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and / or preauthorization may result in a lower payment from the insurance company.

Non-Contracted Insurance: (Out of Network): Insurance is a contract between you and your insurance company. We are **NOT** a party to this contract, in most cases. We accept most insurance and will file all claims for you. The difference is that Out of Network provisions apply for physician services, office visits, diagnostic procedures and surgeries. This does not affect hospital or surgery center services. The other difference is that your insurance company may send the check for services directly to you rather than to us. It is your responsibility to bring the payments along with the explanation of benefits (EOB) to our billing department, so your account can be credited in a timely fashion to avoid finance charges, rebilling and late fees. If you receive a check from your insurance company, you should endorse the back with “Pay to Urology Center of Columbus” and sign your name below. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion of the charges not covered by insurance. If your insurance company requires a referral and / or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and / or preauthorization may result in a lower payment from the insurance company.

Insurance Plans: It is ultimately your responsibility to know the details of coverage and network status of providers for your particular insurance plan. We will always strive to assist you in these determinations, but our relationship is with you and we cannot know the details of every benefit plan.

Divorce: In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for these subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment cost, it is the authorizing parent’s responsibility to collect from the other parent.

Late Fee: A late fee of \$29.00 is applied to any account when the balance or minimum payment is not paid when due.

Rebilling Fee: A rebilling fee of \$10.00 will be imposed on each account that is over thirty (30) days past due. We determine your account is past due by taking the balance owed thirty (30) days ago and then subtracting any payments or credits applied to the account during the time.

Finance Charge: A finance charge will be imposed on each item of your account which has not been paid within thirty (30) days of the time the item was added to the account. The **FINANCE CHARGE** will be computed at the rate of one and a half percent (1 ½%) per month or an **ANNUAL PERCENTAGE RATE** of eighteen (18%) percent. The finance charge on your account is computed by applying the periodic rate of 1 ½% to the “overdue balance” of your account. The “overdue balance” of your account is calculated by taking the balance owed thirty (30) days ago and then subtracting any payments or credits applied to the account during that time. The minimum finance charge is \$2.00.

Past Due Accounts: If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collection costs which are incurred. If we have to refer collection of the balance to a lawyer, you agree to pay all lawyers' fees which we incur plus all court costs. In case of suit, you agree the venue shall be in Muscogee County, Georgia and governed by the laws of the State of Georgia.

Returned Checks: There is a fee (currently \$25.00) for any checks returned by the bank.

Missed Appointment Fee: The second time a patient does not show up on time for an appointment or cancels with less than a 24 hour notice, a \$20.00 fee may be charged. This fee must be paid before a new appointment is scheduled. Patients with three missed appointments may be asked to transfer their records to another doctor.

Credit History: You give us permission to check your credit and employment history and answer questions about your credit experience with us. We have the option to report your account status to any credit reporting agency such as a credit bureau.

Transferring of Records: You will need to request in writing and pay a reasonable copying and postage fee, if you want to have copies of your records sent to another doctor or organization. The amount of the fee is dependent on the number of pages we need to copy. You authorize us to include all relevant information, including your payment history. If you are requesting your records to be transferred from another doctor or organization to us, you authorize us to receive all relevant information, including your payment history. A schedule of fees is available upon request.

Special Forms & Letters: There is a fee (a minimum of \$25.00, may be more depending on the request) for filling out forms and writing letters, etc., that fall outside the normal course of filing insurance claims. This fee must be paid in advance.

Waiver of Confidentiality: You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Responding to a Notice of Address Discrepancy: From time to time, Urology Center of Columbus may request a credit report on patients from a Consumer Reporting Agency for the purpose of making business decisions with respect to a particular patient. Urology Center of Columbus is obligated to:

- i. Compare information from the consumer reporting agency with information Urology Center of Columbus has in our files or have obtained from the patient.
- ii. If we receive a notice of address discrepancy, Urology Center of Columbus is to provide the consumer reporting agency an address that we have reasonably confirmed is accurate.

Worker Compensation: We require written approval / authorization by your employer and / or worker's compensation carrier prior to your initial visit. If your claim is denied, you will be responsible for payment in full.

Personal Injury: If you are being treated as part of a personal injury lawsuit or claim, we require verification from your attorney prior to your initial visit. In addition to this verification, we require that you allow us to bill your health insurance. In the absence of insurance, other financial arrangements must be discussed. Payment of the bill remains the patient's responsibility. We cannot bill your attorney for charges incurred due to a personal injury case.

Co-Signature: If this or another Financial Policy is signed by another person, that co-signature remains in effect until canceled in writing. If written cancellation is received, it becomes effective with any subsequent charges.

Authorized Signature: I authorize the release of any medical or other information necessary to process claims. I also request payment of government benefits either to myself or the party who accepts assignment. I authorize payment of medical benefits to the undersigned physician or supplier for all services.

Effective Date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

Patient Name: _____ **DOB:** _____ **Acct #:** _____ **Date:** _____

Responsible Party: (if not the patient) _____

Signature: _____ **Date:** _____

Co-Signature: _____ **Date:** _____



Acknowledgment of Receipt of Notice of Privacy Practices *(to be filed in patient's medical record)*

Patient Name: _____ DOB: _____ Acct #: _____ Date: _____

I have been presented with a copy of the Notice of Privacy Practices, detailing how my health information may be used and disclosed as permitted under federal and state law, and outlining my rights regarding my health information.

Signed: _____ Date: _____

Relationship (if not signed by patient): _____

For Office Use Only

Signed Acknowledgment of Receipt received on _____ Initials _____

Notice of Privacy Practices given on _____ Initials _____

Patient refused or failed to acknowledge on _____ Initials _____



Pediatric Patient History Form (Below 17 yrs old)

Patient Name: _____ DOB: _____ Acct #: _____

Name Prefer to be Called _____

This is a confidential document. Please answer all sections appropriate to age and problem.

Please describe the main reason for your visit today. _____

1. Where is the problem located? Front Back Side Left Right Other _____

2. How long has the problem existed? __ Days __Week(s) __ Month(s) More than 1 Yr

3. Does anything help the problem? Sitting/Standing Lying Down Pressure Heat/Cold
 Other _____

4. How often does the problem occur? Daily (# of times____) Off & On Constant Infrequently

5. Are there other symptoms associated with this problem? Fever/Chills Nausea/Vomiting Headache Difficult Urinating
 Other _____

6. Does this problem affect your daily life? No Yes; please describe: _____

Circle the number that best describes your problem: Severe ← 10 9 8 7 6 5 4 3 2 1 → Tolerable

7. Have you been treated for this condition in the past? No Yes; please explain _____

Medications

Do you have any **drug allergies**? Yes; please list: _____ No

What type of reaction? _____

Do you take **any** medication? Yes; please list all medications and dosage: _____ No

<u>Medication</u>	<u>Dosage</u>	<u>Frequency</u>	<u>Medication</u>	<u>Dosage</u>	<u>Frequency</u>
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Pharmacy Information

Pharmacy Name _____ Phone _____

Address _____ City _____ State _____ Zip _____

Pharmacy Name _____ Phone _____

Address _____ City _____ State _____ Zip _____

Surgeries/Illness

Have you been hospitalized or undergone a surgical procedure? Yes; please list: No

Surgery/Illness	Date	Physician	Hospital

Medical History

Do you: (Please check all that apply)

Yes No

Female Questions

- have menstrual periods? Yes No Are they regular? Yes No
- use birth control? Yes No Method: _____
- Is there a chance you may be pregnant? Yes No

Social History

- Do you smoke? Yes No
If yes, # of packs per day _____ For how long? _____
 Less than one One Two Three or more
- Do you use smokeless Tobacco? Yes No
If yes, For how long? _____
- Do you drink alcohol? Yes No
 Social Light Moderate Excessive
If yes, how much? _____ For how long? _____

Complete this section if your child is potty trained or has attempted potty training.

At what age was potty training first attempted? _____

Is your child potty trained? Yes No

If yes, at what age? _____

If yes, was potty training Easy Normal Difficult

Does your child wet their pants during the day? Yes No

If yes, constantly? _____ Times per day _____ Times a week _____ Times per month _____

Does your child wet the bed? Yes No

If yes, nightly? _____ Times a week _____ Times per month _____

Have you tried to treat the wetting problem? How? _____

What has been your child's longest dry period? (e.g. 1 month, 6 months, never) _____

How many times a day does your child urinate in a typical day? _____

Does your child have any of the following symptoms during urination?

- Burning Straining to start or maintain a stream Blood in urine Urgency
 Frequency (urinates more than every hour)

Does your child ever complain of lower abdominal pressure while voiding? Yes No

Bowel Habits

How often do you or your child have a bowel movement? _____ x week

Are you or your child ever constipated? Yes No

Do you or your child have fecal soiling in their underwear, more than just poor wiping? Yes No

Do you or your child have bowel movements excessively large? Yes No

Do you or your child have bowel movements excessively hard? Yes No

Do you or your child have frequent stomach aches? Yes No

If yes, how often? _____

Are you experiencing or have you ever experienced any of the following....(Please check all that apply)

Genitourinary

- Blood in Urine
 Pus in Urine
 Frequent urination
 Uncontrolled loss of urine
 Pelvic Pain

Constitutional Symptoms

- Frequent Headache
 Fever/Chills
 Wt. loss _____ lbs

Eyes

- Cataract
 Blurred/Double vision

Ear/Nose/Throat/Mouth

- Ear infection
 Difficulty hearing
 Bleeding Gums
 Sore throat

Respiratory

- Shortness of breath
 Trouble breathing

Gastrointestinal

- Nausea/vomiting
 Abdominal pain
 Constipation
 Diarrhea

Musculoskeletal

- Neck pain
 Back pain

Endocrine

- Excessive thirst
 Tired/sluggish
 "Out of Sorts" feeling

Cardiovascular

- Chest pain
 High blood pressure

Hematologic/Lymphatic

- Swollen glands
 Easy bleeding or bruising

Integumentary

- Skin rash
 Skin lesions

Allergic

- Seasonal Allergies

Neurological

- Depression
 Anxiety
 Sleep Disorder
 Overly Stressed
 Dizzy spells/Vertigo

I have not experienced any of the above.

I/My Family has a history of ... (Please check all that apply)

	Me	Family	Comment		Me	Family	Comment
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	_____	Kidney Diseases	<input type="checkbox"/>	<input type="checkbox"/>	_____
Breast Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chronic Pain	<input type="checkbox"/>	<input type="checkbox"/>	_____	Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Depression/Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	_____	Neurological Disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes, Type 1 or 2	<input type="checkbox"/>	<input type="checkbox"/>	_____	Osteoporosis/Osteopenia	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diverticulosis	<input type="checkbox"/>	<input type="checkbox"/>	_____	Overactive Bladder	<input type="checkbox"/>	<input type="checkbox"/>	_____
Endometriosis	<input type="checkbox"/>	<input type="checkbox"/>	_____	Obesity	<input type="checkbox"/>	<input type="checkbox"/>	_____
Fractures (Bones)	<input type="checkbox"/>	<input type="checkbox"/>	_____	Psychological Disorders	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gout	<input type="checkbox"/>	<input type="checkbox"/>	_____	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____	Stomach Ulcers/Reflux/GERD	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	Seizures	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Cholesterol/Triglyceride	<input type="checkbox"/>	<input type="checkbox"/>	_____	Sickle Cell Anemia	<input type="checkbox"/>	<input type="checkbox"/>	_____
HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	_____	Sleep Disorders	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>	_____	Spine Injury/Surgery	<input type="checkbox"/>	<input type="checkbox"/>	_____
Headache	<input type="checkbox"/>	<input type="checkbox"/>	_____	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	_____	Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hormone Disorders	<input type="checkbox"/>	<input type="checkbox"/>	_____				

IF THERE IS ANYTHING ELSE IN YOUR MEDICAL HISTORY THAT YOU THINK YOUR DOCTOR SHOULD BE AWARE OF NOT INCLUDED ABOVE

PLEASE LIST IT HERE: _____

Patient Signature _____ **Date** ____/____/____

Reviewed By _____ **Date** ____/____/____

Physician Signature _____ **Date** ____/____/____