

NORTH DALLAS UROLOGY ASSOCIATES

5300 W. Plano Parkway, Suite 200
Plano, Texas 75093
972-612-8037 ♦ 972-612-4414 (fax)

4501 Medical Center Drive, Suite 100
McKinney, Texas 75069
972-548-8195 ♦ 972-548-8866 (fax)

Date: _____

First Name: _____ Last Name: _____ MI: _____

Address: _____ Apt/Suite: _____

City: _____ State: _____ Zip: _____

Cell Phone: _____ Work Phone: _____ Home Phone: _____

Social Security #: _____ Date of Birth: _____

Patient Marital Status: S / M / D / W Patient Sex: Male / Female Employed: Yes / No / Ret / Dis

For reporting purposes only:

Primary Language Spoken: _____ Ethnicity: _____ Race: _____

INSURANCE INFORMATION:

Primary Insurance: _____

Name of Policy Owner: _____ DOB: _____ Relation: _____

Secondary Insurance: _____

Name of Policy Owner: _____ DOB: _____ Relation: _____

Do you reside in an ASSISTED LIVING or a NURSING FACILITY? Yes / No

If yes, please fill out the following information:

Name of Facility: _____

Address: _____ Phone: _____

HAVE YOU EVER SEEN ONE OF OUR DOCTORS BEFORE?: YES / NO, If Yes, whom: _____

In case of emergency notify: _____ Phone: _____ Relation: _____

Primary Care Physician: _____ Referred by: _____

How did you hear about us: _____

Plano Office: Mark L. Allen, M.D. ♦ Stephen J. Lieman, M.D. ♦ Vince J. Rogenes, M.D. ♦ J. Scott Hassell, M.D. ♦ Nancy Y. Kim, M.D.
McKinney Office: William C. Mitchell, M.D. ♦ Jared D. Stringer, M.D.

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PATIENT AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Date: _____

Patient Name: _____

Date Of Birth: _____

Description of the specific information to be used or disclosed: (Please check one of the following:)

All information

Or Specific information like the following (Please list below)

- pick up patient's medical records
- cancel, reschedule, make appointments for patient
- call to get patient's results
- pick up patient's medicine/samples

Write names of people we can give out information to and the relationship to them. If you *DO NOT* want us to release any information to anybody, just cross out the page.

Name: _____	Relationship: _____	phone: _____
Name: _____	Relationship: _____	phone: _____
Name: _____	Relationship: _____	phone: _____
Name: _____	Relationship: _____	phone: _____
Name: _____	Relationship: _____	phone: _____

I understand that:

- I may inspect or copy the protected health information to be used or disclosed.
- I may revoke this authorization in writing by contacting your office at the address above, attention Privacy Officer.
- Information used or disclosed pursuant to the Authorization may be subject to re disclosure by the recipient and no longer be protected by HIPAA.

Patient Signature: _____ Date: _____

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FINANCIAL RESPONSIBILITY AGREEMENT

I, _____, understand that I am responsible for all charges incurred for my medical treatment. I consent that medical benefits from my insurance policy are paid directly to North Dallas Urology Associates, in consideration of services rendered up to the total amount of my account.

Any balance remaining after insurance benefits have been paid is my responsibility. I will pay the balance within 60 days unless other arrangements have been made. I understand that in the event of default, my account will be sent to a collection agency.

It is my responsibility to provide the correct insurance information (claims address, phone numbers, ID numbers, etc.). I will pay any balances resulting from inaccurate insurance information.

NORTH DALLAS UROLOGY will file claims with my primary and secondary insurance companies ONLY. If I have a third insurance company, I will file those claims myself. I understand that I am responsible for all remaining balances after my second insurance company has paid.

Every possible effort will be made to obtain payment for my claims. I agree to pay my account balance in the event the insurance company(ies) do not respond.

ALL COPAYS AND DEDUCTIBLES ARE DUE AT TIME OF SERVICE. I also agree to pay for in-office labs/x-rays/tests at the time of service as outlined by my insurance company.

There is a \$45.00 fee for disability forms that need to be completed prior to surgery or any form requiring dictation by the doctor, and a \$25.00 fee for a copy of your medical records.

It is my responsibility to obtain all referrals and to verify the in-network status of my doctor. If I do not have a proper referral, my appointment will be rescheduled until one is obtained.

I authorize the release of medical records necessary to process insurance claims.

Signature: _____ Date: _____

Physician Disclosure

To further our commitment to the quality of medical and surgical care for our patients, we have chosen to be an owner in the entities listed below.

Our ownership enhances our ability to direct the manner in which your care is delivered at the facility. If this of concern to you, the Physicians' will be happy to answer any questions.

We are on the medical staff at other healthcare facilities and will be happy to discuss your option of choosing an alternative location.

**Surgery Center of Plano
Upright & Open Imaging
McKinney Surgery Center
Baylor Medical Center at Frisco
North Dallas Radiation Oncology Center
Methodist McKinney Hospital
US Lithotripsy**

ACKNOWLEDGEMENT: (I / We) have read this "Notice to Patients" form, and (I / We) understand the disclosures that it contains.

Date this _____ Day of _____, 20____

Signature of Patient or Guardian

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up care among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payors.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

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Patient Name: _____ Date: _____

Signature of patient (or Authorized Representative): _____

Relationship to Patient: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement of this *Notice of Privacy Practices Acknowledgement*, but was unable to do so as documented below:

DATE: _____ INITIALS: _____ REASON: _____

Signature: _____

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PAYMENT POLICY

Upon contact with our business office, we will request your insurance information. We are required by many insurance companies to get pre-certification numbers and benefits. This protects you as well as us from having unexpected out-of-pocket expenses. Our staff will call your insurance company to verify your benefits and also check on your current deductible, co-payment, and coinsurance. This information will be shared with you. In order to control our billing costs, we request the deductible, co-payment, and/or coinsurance be paid as they relate to the charges at the time of service. Payment may be made by cash, check, MasterCard, Visa, Discover, or American Express.

MEDICARE PATIENTS

If your primary insurance is Medicare, then we will file the claim for you. We do accept Medicare assignment which means we will bill you only what Medicare allows. Medicare will pay 80% of the allowable, minus any deductibles, and you will be responsible for the other 20% allowable plus any remaining deductible. If you have a secondary insurance policy, we will file that for you as a courtesy. Some secondary insurance policies reimburse directly to the patient and/or insured. If your insurance company does this, please forward the payment to us in the form of cash, check, or credit card.

Note: At times, there may be a procedure or test done in-office that is required to be sent out to a lab or pathologist. In these cases you may be billed by a third party for these services.

LABS

We, out of courtesy collect your specimen and send it to our preferred lab for processing and analyzing of results. We do not have the capability to provide this service in our office, therefore if you do not wish to have your specimen collected or sent to our preferred laboratory please specify prior to services. We use the following laboratories: LabCorp, Bostwick & Dr. Donna Sirbasku, Pathologist

MANAGED CARE PATIENTS

We request you pay your co-payment at the initial onset of your visit. If your deductible has not been met for the year, you will also need to pay any unmet deductible for the services rendered. After your deductible has been met, you will then be responsible for only your co-payment and/or coinsurance. Any procedure done, may be subject to an additional surgical deductible depending on your particular insurance plan. We will file all claims for the services rendered by the physician.

Assignment of insurance benefits, deductible, co-payments, and/or coinsurance are required before elective surgery. We will try to fulfill all insurance requirements for pre-certification; however, we cannot be responsible for reduction in benefits if this is not done. Therefore, we encourage you to contact your insurance company before any surgical procedures are done.

Note: At times, there may be a procedure or test done in-office that is required to be sent out to a lab or pathologist. In these cases you may be billed by a third party for these services.

Please be advised that we request 24-hour cancellation notice prior to your scheduled appointment.

Assignment of Benefits

I authorize release of medical records to determine liability for payment and to obtain reimbursement. I assign all medical and/or surgical benefits including Medicare, private insurance, and other health plans to my physician. This assignment will remain in effect until revoked by me in writing. I understand I am financially responsible for all charges incurred by myself and/or my dependent.

Signed: _____ Date: _____
Parent or guardian if patient is a minor: _____

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NAME: _____ DATE: _____

Primary Care or Referring Physician: _____

Pharmacy Name: _____ Location: _____ Phone: _____

LIST OF SURGERIES/ PAST MEDICAL HISTORY

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

PRESCRIPTION/

<u>OVER THE COUNTER:</u>	<u>MG (dosage)</u>	<u>TIMES A DAY?</u>	<u># Per Day</u>
--------------------------	--------------------	---------------------	------------------

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

ALLERGIES TO MEDICATION:

- | | |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

Do you take aspirin or Arthritis Prescriptions?	YES	NO
Have you ever smoked or used tobacco products?	YES	NO
Do you drink alcohol now or in the past?	YES	NO
Are you allergic to iodine or dye contrast?	YES	NO
Do you have prostate cancer in your family?	YES	NO

FAMILY HISTORY OF MEDICAL ILLNESS:

Father: _____	Paternal grandfather: _____
Mother: _____	Paternal grandmother: _____
Maternal grandfather: _____	Maternal grandmother: _____

What symptoms are you having today?

NAME: _____

DATE: _____

- | | |
|--|---|
| <input type="checkbox"/> Fever | <input type="checkbox"/> Chest Pain |
| <input type="checkbox"/> Chills | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Swelling of ankles |
| <input type="checkbox"/> Pain | <input type="checkbox"/> Joint Pain |
| <input type="checkbox"/> Sore Throat | <input type="checkbox"/> Neck Pain |
| <input type="checkbox"/> Sinus Pain | <input type="checkbox"/> Back Pain |
| <input type="checkbox"/> Mouth Ulcers | <input type="checkbox"/> Urinary Incontinence |
| <input type="checkbox"/> Runny Nose | <input type="checkbox"/> Pain with Urination |
| <input type="checkbox"/> Tremor | <input type="checkbox"/> Urinary Urgency |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Urinary Frequency |
| <input type="checkbox"/> Tingling/numbness | <input type="checkbox"/> Urinary Retention |
| <input type="checkbox"/> Too Hot/Cold | <input type="checkbox"/> Pain with Intercourse |
| <input type="checkbox"/> Tired/Sluggish | <input type="checkbox"/> Erectile Dysfunction |
| <input type="checkbox"/> Loss of Libido | <input type="checkbox"/> Wheezing |
| <input type="checkbox"/> Rash | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Itching | <input type="checkbox"/> Seasonal Allergies |
| <input type="checkbox"/> Boils | <input type="checkbox"/> Swollen Glands |
| <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Blood Clotting Problem |
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Heartburn | <input type="checkbox"/> Double Vision |
| <input type="checkbox"/> Diarrhea | |
| <input type="checkbox"/> Constipation | |