UROLOGY, P.C.

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The physicians and staff of Urology, P.C. would like to welcome you to our facility. Please bring all completed forms with you to your appointment.

Please arrive 15 minutes prior to your appointment time, this will allow us to make your experience here more pleasant and efficient. It is important for us to meet your medical needs; therefore, we feel the following information is needed:

1) Medical information pertaining to your visit
2) List of your prescriptions or over-the-counter or herbal medications including doses
3) Lab results (urine cultures, PSA, blood work, etc.)
4) X-rays (actual films preferred)
5) Referrals or Pre-authorizations if required by your Insurance
6) All Insurance Cards (Medicare, Medicaid, etc.)
7) Photo ID (Driver's License, Military ID, etc.)

We are located on the NW corner of 56th & Pine Lake Road in Lincoln, Nebraska. If you have any further questions or concerns regarding the above information please feel free to contact us at (402) 489-8888 and we will be happy to assist you.

We look forward to caring for you.

Urology, P.C.

visit us at www.lincolnurologypc.com

PATIENT REGISTRATION FORM FOR
UROLOGY P.C. & UROLOGY SURGICAL CENTER

Referring Physician:

Primary Care Physician:

Today's Date

PATIENT INFORMATION

Patient's Last Name:	First:	M.I.	Birth Date:	Sex: ❑ Male ❑ Female

Is this the patient's legal name? ❑ Yes ❑ No	If no, what is the patient's legal name?	Former name(s):

Marital Status: ❑ Single ❑ Married ❑ Widowed ❑ Divorced ❑ Separated

SSN:

Street Address:	Billing Address (if different):

City	State	Zip Code	Home Phone: ( ) Cell Phone: ( )

Current Work Status: ❑ Full Time ❑ Part Time ❑ Retired ❑Disabled ❑ Not Employed

Occupation:	Employer Name	Address:	Work Phone & Ext.: ( )

Current School Status: ❑ Full Time ❑ Part Time

Name of School:

PRIMARY CONTACT PERSON (SPOUSE, PARENT, SIGNIFICANT OTHER, ETC.)

Name:	SSN:	DOB:	Relationship:

Address:	Employer:

Home Phone: ( )	Work Phone: ( )	Cell Phone: ( )

SECONDARY CONTACT PERSON (PARENT, CHILD, NEXT OF KIN, ETC.)

Name:	Relationship:
Address:	Employer:

Home Phone: ( )	Work Phone: ( )	Cell Phone: ( )

INSURANCE COVERAGE

Is this patient a Ward of the State? ❑ Yes ❑ No

Case Manager:

Is this patient covered by insurance? ❑ Yes ❑ No **If yes, please complete appropriate insurance information below.**

MEDICARE COVERAGE (specify)	MEDICAID (WELFARE) COVERAGE
Is Medicare Primary? ❑ Yes ❑ No	Is this patient covered by Medicaid? ❑ Yes ❑ No
Medicare #	Medicaid Plan #
Railroad Medicare #	Coventry NE #
Medicare (Hospital Only) #	Share Advantage #
Medicare Advantage Plan (Unicare, Secure Horizons, etc.)	Case Worker's Name:
Plan Name:	
Plan #	Case Worker's Phone:

OTHER INSURANCE COVERAGE

Insurance Company & Address:	Primary Insurance: ❑ Yes ❑ No

Subscriber's Name	Subscriber's SSN	Subscriber's Date of Birth	Is this a Self/Individual Plan? ❑ Yes ❑ No

Policy #	Group #	Subscriber's Relationship to Patient	Subscriber's Employer

OTHER INSURANCE COVERAGE

Insurance Company & Address:	Primary Insurance: ❑ Yes ❑ No

Subscriber's Name	Subscriber's SSN	Subscriber's Date of Birth	Is this a Self/Individual Plan? ❑ Yes ❑ No

Policy #	Group #	Subscriber's Relationship to Patient	Subscriber's Employer

(over)

What is your preferred pharmacy? ________________________________ Location _________________________

Race/Ethnicity (circle one): **White** **Hispanic/Latino** **Black/African American** **Asian** **Multi-Racial** **Other**

Preferred Language (circle one): **English** **Other** ____________________ ❑ Interpreter Required

Is this medical condition due to an accident of any kind? **YES** **NO**

If yes, was it (choose one): **Work Related** **Auto** **Home** **Other**

Do you have a Living Will or Advanced Directive (please bring a copy with you)? **YES** **NO**

Do you have a Medical Power of Attorney (please provide documentation)? **YES** **NO**

If yes, please indicate name, address & phone: ____

____

MEDICARE PATIENTS ONLY complete information in box:

If you are <u>not</u> a Medicare patient, please continue below the box.

1. Are you a Veteran? **YES** **NO**

   If yes, were you referred to us by the VA? **YES** **NO**

   If yes, do you have a written referral for today? **YES** **NO**

2. Do you have a Federal Black Lung Card? **YES** **NO**

3. Do you have a Veterans FEE BASIS ID card? **YES** **NO**

4. Are you covered by a current employer's health insurance plan through you or your spouse's employer?

   YES **NO**

5. Are you entitled to Medicare because of disability or End Stage Renal Disease? **YES** **NO**

→ AUTHORIZATION TO TREAT

I authorize and direct my physician and his/her designee to provide medical services and diagnostic services for me as they deem necessary and appropriate including but not limited to services involving pathology and radiology. I understand that I have the right to receive information, to ask questions and to receive answers to my questions about my treatment plan. I also have the right to refuse treatment and to seek a second opinion.

→ ASSIGNMENT OF BENEFITS

I hereby assign all medical and/or surgical insurance benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance and any other health plans to the physician caring for me. **I understand that I am financially responsible for all allowed charges or co-insurance amounts which are not paid by my insurance company.**

→ RELEASE OF INFORMATION TO INSURANCE COMPANY

I authorize Urology, PC and/or Urology Surgical Center to release to the Medicare carrier and/or the Insurance Carrier listed above, any information needed for this or a related claim. I permit a copy of this authorization to be used in place of the original and request payment of this claim be made directly to Urology, PC or Urology Surgical Center.

→ NEBRASKA STATE LAW REGARDING MINORS - Nebraska state law defines a minor as anyone 18 years of age and younger. These patients are required by this law to have a legal guardian present or if this is not possible, you must make prior arrangements with our office. If prior arrangements are not made, it could result in the appointment needing to be rescheduled.

→ I understand there will be a $25 fee for a no show appointment or returned check (See also Financial Policy) payable only by cash, money order, credit or debit card.

I understand that I will be responsible for all charges if the listed insurance information is not correct.

Signature____ Date ______________________

Urology, P.C. / Urology Surgical Center **HEALTH HISTORY QUESTIONNAIRE**

Date	Patient Name	Date of Birth	Sex	Ht	Wt

Reason for Today's Visit:

ALLERGIES (MEDICAL)

To What	Reactions	To What	Reactions

Do you have a Latex Allergy or Sensitivity (circle one)? **Allergy** **Sensitivity** **None**
Have you taken Cortisone, Prednisone, or Steroids for any condition in the past 6 months? **No** **Yes**
Any total joint or implant surgery? **No** **Yes**
Have you ever been told you have a heart condition which requires you to take antibiotics prior to medical or dental treatment? **No** **Yes** (list condition) ________________________

MEDICATIONS / PRESCRIPTIONS / OVER-THE-COUNTER MEDICINE / INHALERS / VITAMINS / ASPIRIN

Name & Dose	Frequency	Last Dose	Name & Dose	Frequency	Last Dose

PREVIOUS SURGERIES / HOSPITALIZATION (LIST MOST RECENT FIRST)

Type	Date

Please check yes or no for each statement and if choices listed, circle each that apply to your health history:

FAMILY HISTORY (BLOOD RELATIVES)	Yes	No
Heart?		
Hypertension (High Blood Pressure)?		
Bleeding tendencies?		
Cancer?		
Diabetes?		
Anesthetic problems? Fever during surgery?		
Neurological?		
Any other medical conditions not addressed above?		

SOCIAL HISTORY (Patient)	Yes	No
Smoker? If yes, packs per day?		
Ex-Smoker? Quit Date:		
Other tobacco use? How much?		
Alcohol use? How much?		
Drug use? How much?		
Occupation:		
Religious restrictions?		

COMMENTS:

CARDIOVASCULAR / HEART (Patient)	Yes	No
High Blood Pressure?		
Chest pain at rest or during exercise?		
Heart failure / Congestive heart failure?		
History of heart attack? Date:		
Pacemaker?		
Fainting / Dizzy?		
History of Murmur / rheumatic fever / valve disorder?		
Has a doctor told you that you have a heart rhythm problem?		
Swelling in legs / Severe calf pain when walking?		

RESPIRATORY / LUNGS (Patient)	Yes	No
History of asthma / wheezing?		
Emphysema / COPD / Chronic bronchitis?		
Recent cold / flu / pneumonia?		
Shortness of breath at rest or during exercise?		
Night sweats / tuberculosis / coughing up blood?		
Recent or chronic cough?		

COMMENTS:

HEMATOLOGY / BLOOD	Yes	No
Anemia?		
Bleeding problems / bruise easily?		
Leukemia / sickle cell anemia?		
Blood Clots?		
Self-donated blood available?		
Blood donated to you?		
Prior Transfusion?		
Transfusion reaction?		

COMMENTS:

KIDNEY / BLADDER	Yes	No
Kidney disorder (failure / stones / infections)?		
Dialysis patient?		
Kidney transplant?		
Burning with urination?		
Difficulty passing urine?		
Difficulty controlling urine?		
Getting up at night to urinate? How many times?		
Blood in urine?		

COMMENTS:

Urology, P.C. / Urology Surgical Center

HEALTH HISTORY QUESTIONNAIRE

ORTHOPEDIC / NEUROLOGICAL / MUSCULAR	Yes	No
Arthritis?		
Limited movement / Affected Area?		
Seizure / epilepsy / convulsions?		
Stroke / brief weakness / paralysis?		
Multiple sclerosis?		
Head injury?		
Muscle disorders / weakness / Cerebral Palsy?		
Back or neck disorder?		
Amputation / prosthesis?		
Headaches?		
Parkinson's?		
Muscular dystrophy?		
Painful or swollen joints?		

GASTROINTESTINAL / STOMACH	Yes	No
Hiatal hernia / heartburn at night / reflux?		
Ulcers / gastritis / vomiting blood?		
Rectal problems or bleeding?		
Recent change in bowel habits?		
Frequent abdominal pain?		
Gallbladder problems?		
Black tar-like bowel movements?		
COMMENTS:		

LIVER	Yes	No
Hepatitis / cirrhosis?		
Jaundice?		

FEMALE GENITALIA	Yes	No
Venereal disease (syphilis, gonorrhea, etc.)?		
Sexual problems?		
Irregular periods?		
Abnormal vaginal bleeding or spotting (not with periods)?		
Severe cramps with periods?		
Abnormal pap test? Date of last pap test?		
Age at onset of periods:		
Periods are: Heavy Medium Light		
Date last menstrual period started:		
Could you be pregnant?		
Birth control method:		
Number of full-term pregnancies:		
Number of premature deliveries:		
Number of abortions or miscarriages:		
Number of living children:		
Cesarean birth?		

MALE GENITALIA	Yes	No
Prostate problem?		
Venereal disease (syphilis, gonorrhea, etc.)?		
Sexual Problems?		
Discharge from penis?		
Lump in testicles?		
COMMENTS:		

INFECTIONS	Yes	No
Have you had any recent infections?		
Have you been exposed to any infectious disease?		
Tetanus? Last Dose:		
Hepatitis B? Last Dose:		
Pneumo Vaccination? Last Dose:		

ENDOCRINE	Yes	No
Diabetes? If yes, insulin dependent?		
Problems with your glands? If yes, Thyroid, Pituitary, other		

COMMENTS:

GENERAL	Yes	No
Cancer / Chemotherapy / Radiation Therapy?		
Anxiety / Depression / Psychiatric disorder?		
Cataracts / Glaucoma?		
Recent Fall?		

ANESTHESIA HISTORY	Yes	No
Unexplained fever during surgery?		
Severe nausea and/or vomiting		
History of difficult intubations?		
Airway, breathing, sleep apnea, snoring problems?		
Difficulty in waking after anesthesia?		
Dentures / bridgework / loose teeth?		
History of TMJ / difficulty opening mouth?		

PEDIATRIC SURGERY INFORMATION	Yes	No
If a child is having surgery:		
Has your child had chicken pox?		
If not, has he/she been exposed in the past 3 weeks?		
Was your child born prematurely?		
If yes, how many weeks early?		
Developmental delays as a child?		

Additional Comments / Concerns:

Form Completed by: ______________________ Date: ______________

Medications and Allergies reviewed by: ______________

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In order to accommodate the needs and requests of our patients we have enrolled in numerous managed care insurance programs.

While we are pleased to be able to provide this service to you, it is extremely difficult for us to keep track of all the individual requirements of the plans. Each one has different stipulations regarding how often services may be rendered and, even more importantly, where those services may be performed.

Even within the same insurance company, the plans differ depending upon what type of contract your employer has negotiated.

Providing quality medical care for our patients is our primary concern. We are more than willing to provide that care within your insurance contract guidelines if you let us know at EACH time of service *exactly* what those guidelines are.

Unfortunately, if you do not inform us of any special requirement in your contract and we subsequently order services, such as lab work or hospitalization, that are not covered, we or the selected medical facility will have no choice but to bill you directly for those charges. Payment for those charges is then your responsibility.

With your cooperation and help, you should be able to receive all of the benefits offered to you, and we will be able to concentrate on caring for your medical needs.

Additionally, we will collect a co-pay as indicated on your insurance card. However, insurance policies vary and the possibility remains your insurance company may apply your charges to a deductible or require additional co-insurance to be paid by the patient. We have no control over how your claim is processed by your insurance company and any issues related to processing of claims must be addressed with your insurance carrier.

I have read and understand the office policy stated above and agree to accept responsibility as described.

Printed Name: ____

Signature: ____ Date: __________

UROLOGY, P.C./UROLOGY SURGICAL CENTER

5500 Pine Lake Road, Lincoln, NE 68516 Phone: (402) 489-8888 Fax: (402) 421-1945

FINANCIAL POLICY

We would like to take this opportunity to welcome you to our office and to assure you that Urology, P.C. / Urology Surgical Center is committed to providing you with the best possible care. Please read the following information regarding our Financial Policy.

If you have insurance coverage, as a courtesy, we will file ALL insurance claims, as long as an assignment of benefits is given to us. We participate with most of the major insurance companies. Please contact your insurance company if you have any questions regarding participation. Please remember the following regarding insurance:

- You are ultimately responsible for follow up with your insurance company regarding payment of your claim
- Your insurance is a contract between you and your insurance company
- Not all services are a covered benefit in all insurance policies
- You are responsible for any balance due on your account
- We reserve the right to pre-collect on any medical condition which may not be covered by insurance.

Please contact our billing department promptly at **402-489-8888 option 4** if you have questions or are unable to pay your bill in full within 30 days of the first statement you receive.

If you have no insurance coverage, you will be required to pay $50 at the time of your visit; you will be billed for any additional charges. Payment arrangements are made in advance with our Patient Account Manger or billing department. To assist you, we accept cash, check, MasterCard, Visa and Discover. There will be a $25 charge on all returned checks.

Remember to bring the following items along with you to your appointment:

- Your current insurance card
- Co-pay required by your insurance company
- A referral from your primary care physician, if your insurance requires one

Should you desire, we can provide you an estimate of your financial obligations regarding any proposed treatment/surgery. Please contact us promptly for assistance in the management of your account. We do use outside agencies as a means of collections should we deem it necessary. If you have any questions about the above information or any uncertainty regarding insurance coverage, do not hesitate to contact us at **402-489-8888 option 4**.

THERE WILL BE A $25 FEE FOR ANY NO SHOWS WHICH MUST BE PAID PRIOR TO RESCHEDULING PAYABLE ONLY BY CASH, CREDIT OR DEBIT CARD, OR MONEY ORDER.

Revised 6/30/2010