



UROLOGY, P.C.

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

R.A. Crusinberry, M.D.
D.L. Henslee, M.D.
P.E. Howe, M.D.
S.S. Lacy, M.D.
C.E. Larson, M.D.
A.J. Lepinski, M.D.
L.A. Wiebusch, M.D.
D.B. Wiltfong, M.D.

M.K. Fulton, APRN-C
C.T. Bock, PA-C
K.A. Wragge, PA-C

VASECTOMY INFORMATION

Patient Name: _____ Date of Birth _____

You are currently scheduled for a vasectomy consult at Urology P.C. Please be aware, if you want to proceed, the *scheduling* of the procedure will take place while you are here for the consultation. We are currently scheduling about 8 weeks out from the date of your consultation.

We are enclosing information that you will need to request from your insurance company prior to your appointment. It is essential that you find out if sterilization is a covered benefit under your insurance plan. Since vasectomies are an elective procedure we have a policy to collect payment prior to the procedure. We will submit your insurance for you but you will be responsible for any co-insurance or deductible that may be applied. We ask that you contact your insurance company and find out the following regarding your benefits: Please obtain the name of the person you talk to at the insurance co. and the date.

Customer Service Person _____ Date _____

- 1) Is sterilization (Vasectomy 55250) a covered benefit? Yes or No
(this is an out-patient procedure, it is NOT done in the office)
- 2) Is there a deductible? Yes or No
If Yes, How much is it? _____ Have I met it for the year? _____
How much is left to be applied? _____.
- 3) The vasectomy will be done in an outpatient facility; either Urology Surgical Center or at the hospital as an outpatient (not in the office). Find out if there is a different deductible that applies for an outpatient facility?
- 4) Is precertification required? Yes or No

You will need to find out if our physician and/or surgery center are in Network with your insurance (specify which physician you are seeing). If our Surgery Center is not in network, see which hospital in Lincoln is in Network as you may want to have the procedure scheduled there. You will also need to find out if your plan pays in-network 80%, 85% or 90%, or the percent of out-of-network _____%.

- 5) Payment for any co-insurance or deductible amount is due prior to surgery. These amounts are strictly an estimate based on information from your insurance company.

UPC _____
Urology PC

ASC _____
Urology Surgical Center

Please bring this completed form to your appointment; we will finalize the information in patient accounts before your surgery is scheduled.

If you have further questions or concerns regarding the above information please feel free to contact our billing department at 402-489-8888 Option 4, or Ext 221.

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

Referring Physician:	Today's Date
Primary Care Physician:	

PATIENT INFORMATION

Patient's Last Name:	First:	M.I.	Birth Date:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Is this the patient's legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No		If no, what is the patient's legal name?		Former name(s):
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Separated			SSN:	
Street Address:			Billing Address (if different):	
City	State	Zip Code	Home Phone: ()	
			Cell Phone: ()	
Current Work Status: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Retired <input type="checkbox"/> Disabled <input type="checkbox"/> Not Employed				
Occupation:	Employer Name	Address:	Work Phone & Ext.: ()	
Current School Status: <input type="checkbox"/> Full Time <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	Case Manager:
Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please complete appropriate insurance information below.	
MEDICARE COVERAGE (specify)	MEDICAID (WELFARE) COVERAGE
Is Medicare Primary? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is this patient covered by Medicaid? <input type="checkbox"/> Yes <input type="checkbox"/> 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:	Case Worker's Phone:
Plan #	

OTHER INSURANCE COVERAGE

Insurance Company & Address:			Primary Insurance: <input type="checkbox"/> Yes <input type="checkbox"/> No
Subscriber's Name	Subscriber's SSN	Subscriber's Date of Birth	Is this a Self/Individual Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No
Policy #	Group #	Subscriber's Relationship to Patient	Subscriber's Employer

OTHER INSURANCE COVERAGE

Insurance Company & Address:			Primary Insurance: <input type="checkbox"/> Yes <input type="checkbox"/> No
Subscriber's Name	Subscriber's SSN	Subscriber's Date of Birth	Is this a Self/Individual Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No
Policy #	Group #	Subscriber's Relationship to Patient	Subscriber's Employer

(over)

1. What is your preferred pharmacy? _____ Location _____

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

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

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

4. 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 not 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 _____

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	SOCIAL HISTORY (Patient)	Yes	No
Heart?			Smoker? If yes, packs per day?		
Hypertension (High Blood Pressure)?			Ex-Smoker? Quit Date:		
Bleeding tendencies?			Other tobacco use? How much?		
Cancer?			Alcohol use? How much?		
Diabetes?			Drug use? How much?		
Anesthetic problems? Fever during surgery?			Occupation:		
Neurological?			Religious restrictions?		
Any other medical conditions not addressed above?			COMMENTS:		

CARDIOVASCULAR / HEART (Patient)	Yes	No	RESPIRATORY / LUNGS (Patient)	Yes	No
High Blood Pressure?			History of asthma / wheezing?		
Chest pain at rest or during exercise?			Emphysema / COPD / Chronic bronchitis?		
Heart failure / Congestive heart failure?			Recent cold / flu / pneumonia?		
History of heart attack? Date:			Shortness of breath at rest or during exercise?		
Pacemaker?			Night sweats / tuberculosis / coughing up blood?		
Fainting / Dizzy?			Recent or chronic cough?		
History of Murmur / rheumatic fever / valve disorder?			COMMENTS:		
Has a doctor told you that you have a heart rhythm problem?					
Swelling in legs / Severe calf pain when walking?					

HEMATOLOGY / BLOOD	Yes	No	KIDNEY / BLADDER	Yes	No
Anemia?			Kidney disorder (failure / stones / infections)?		
Bleeding problems / bruise easily?			Dialysis patient?		
Leukemia / sickle cell anemia?			Kidney transplant?		
Blood Clots?			Burning with urination?		
Self-donated blood available?			Difficulty passing urine?		
Blood donated to you?			Difficulty controlling urine?		
Prior Transfusion?			Getting up at night to urinate? How many times?		
Transfusion reaction?			Blood in urine?		

COMMENTS:

COMMENTS:

ORTHOPEDIC / NEUROLOGICAL / MUSCULAR	Yes	No	GASTROINTESTINAL / STOMACH	Yes	No
Arthritis?			Hiatal hernia / heartburn at night / reflux?		
Limited movement / Affected Area?			Ulcers / gastritis / vomiting blood?		
Seizure / epilepsy / convulsions?			Rectal problems or bleeding?		
Stroke / brief weakness / paralysis?			Recent change in bowel habits?		
Multiple sclerosis?			Frequent abdominal pain?		
Head injury?			Gallbladder problems?		
Muscle disorders / weakness / Cerebral Palsy?			Black tar-like bowel movements?		
Back or neck disorder?			COMMENTS:		
Amputation / prosthesis?					
Headaches?					
Parkinson's?					
			LIVER	Yes	No
Muscular dystrophy?			Hepatitis / cirrhosis?		
Painful or swollen joints?			Jaundice?		

FEMALE GENITALIA	Yes	No	MALE GENITALIA	Yes	No
Venereal disease (syphilis, gonorrhea, etc.)?			Prostate problem?		
Sexual problems?			Venereal disease (syphilis, gonorrhea, etc.)?		
Irregular periods?			Sexual Problems?		
Abnormal vaginal bleeding or spotting (not with periods)?			Discharge from penis?		
Severe cramps with periods?			Lump in testicles?		
Abnormal pap test? Date of last pap test?			COMMENTS:		
Age at onset of periods:					
Periods are: <input type="checkbox"/> Heavy <input type="checkbox"/> Medium <input type="checkbox"/> Light					
Date last menstrual period started:					
Could you be pregnant?					
Birth control method:			INFECTIONS	Yes	No
Number of full-term pregnancies:			Have you had any recent infections?		
Number of premature deliveries:			Have you been exposed to any infectious disease?		
Number of abortions or miscarriages:			Tetanus? Last Dose:		
Number of living children:			Hepatitis B? Last Dose:		
Cesarean birth?			Pneumo Vaccination? Last Dose:		

ENDOCRINE	Yes	No	GENERAL	Yes	No
Diabetes? If yes, insulin dependent?			Cancer / Chemotherapy / Radiation Therapy?		
Problems with your glands? If yes, Thyroid, Pituitary, other			Anxiety / Depression / Psychiatric disorder?		
COMMENTS:			Cataracts / Glaucoma?		
			Recent Fall?		

ANESTHESIA HISTORY	Yes	No	PEDIATRIC SURGERY INFORMATION	Yes	No
Unexplained fever during surgery?			If a child is having surgery:		
Severe nausea and/or vomiting			Has your child had chicken pox?		
History of difficult intubations?			If not, has he/she been exposed in the past 3 weeks?		
Airway, breathing, sleep apnea, snoring problems?			Was your child born prematurely?		
Difficulty in waking after anesthesia?			If yes, how many weeks early?		
Dentures / bridgework / loose teeth?			Developmental delays as a child?		
History of TMJ / difficulty opening mouth?					

Additional Comments / Concerns:

Form Completed by: _____ Date: _____

Medications and Allergies reviewed by: _____



UROLOGY, P.C.

5500 Pine Lake Road · Lincoln, Nebraska 68516 · (402) 489-8888 · Fax (402) 421-1945

R.A. Crusinberry, M.D.
D.L. Henslee, M.D.
P.E. Howe, M.D.
S.S. Lacy, M.D.
C.E. Larson, M.D.
A.J. Lepinski, M.D.
L.A. Wiebusch, M.D.
D.B. Wiltfong, M.D.

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 Manager 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.