UROLOGY SURGEONS, P.C.

AUTHORIZATION AND CONSENT

TO RELEASE INFORMATION

In the event that Urology Surgeons PC needs to communicate with you regarding test results or other pertinent medical information, do you give permission for us to leave this information on your voicemail or answering machine? ____Yes ____No. If Yes, what is the best phone number to reach you? _____.

I hereby grant permission to UROLOGY SURGEONS, P.C. to release my protected health information to the following family members and/or friends who may be involved in my care:

PLEASE PRINT

_____

_____

_____

Patient (print name) _____

Patient Signature _____ Date _____

UROLOGY SURGEONS
FINANCIAL POLICY

Thank you for choosing our practice. We value the opportunity to help you through your urologic problem and look forward to engaging you as we make diagnostic and treatment decisions together. We hope that you will recognize that our financial policy is a necessary part of assuring the resources required to maintain this health care service for our patients and for the community.

Charges for medical services are due and payable at the time services are rendered. Charges for medical care provided by this medical practice will be billed through our office and should not be confused with charges for medical care provided by the hospital. We accept Visa, MasterCard, Discover and American Express as well as personal checks, money orders, debit cards and cash. There is a $2.75 convenience fee for credit card payments made online or over the phone. **Broken Appointments**: A specific amount of time is reserved especially for you and we strongly encourage all patients to keep their appointments. **If you must change your appointment, we kindly ask for at least 24-hour notice to avoid a $50.00 fee.**

We bill your insurance company for your health care costs. It is extremely important that we obtain complete information about your primary and supplemental insurance companies, including phone numbers, addresses and a copy of your insurance card(s).

Preauthorization for second surgical opinions are becoming a requirement for many insurance companies. We insist that when a surgery or procedure (MRI scans, CT scans, outpatient surgery) is scheduled, that you contact your insurance company immediately to determine what, if any, preauthorization requirements the insurance company deems necessary before the surgery or procedure. You will need to initiate the communication between you and the insurance company. We cannot stress enough how important it is for you to be aware of your insurance company's requirements on office visits, procedures, hospitalization, and surgery. Your insurance company can deny payment or drastically reduce payment for services that are provided if their requirements are not met.

If you have health insurance, this is an agreement between you and your insurance company. Your doctor's bill, on the other hand, is an agreement between you and your doctor. You are responsible for the payment of your doctor's bill regardless of the status of your insurance claim. If unusual circumstances should make it impossible for you to meet our payment terms, we invite you to call or personally discuss the matter with our billing specialist. This will avoid misunderstandings and enable you to keep your account in good standing. Accounts 60 days past due may be referred to a collection agency. Your account with us is then considered terminated.

Insurance Participation: We participate with most insurance companies and will submit charges directly to the insurance company for payment of services provided. You can call our office to see if we participate with your insurance company. You will be asked to pay any co-pays at the time of service. Some services may be deemed non-covered or medically unnecessary by your insurance company. If so, you are directly responsible for the charges incurred. Any balance remaining after the insurance payment is made is due to our office within 30 days.

Non-Participation with Insurance: Patients, who have policies with insurance companies we do not contract with, will be responsible for payment of all office visits at the time service is rendered. Some non-contracted insurance companies will pay an out of network benefit to our office for services. However, you will be responsible for the remaining balance. If you are scheduled to undergo surgery by one of our physicians, you can ask our billing specialist for a surgery estimate. This estimate can be used to contact your insurance company to determine their level of reimbursement and to initiate the preauthorization process. We can make payment arrangements over a six-month period on patient balances. however, we accept Visa, MasterCard, Discover and American Express.

Cash Patients: Payment will be expected at the time of service. A minimum of $250 for the initial consultation is expected at the time of service. Due to the nature of the visit, there may be additional charges.

Patient Responsibility: Any unpaid balances over 60 days may be referred to a collection agency. Your account with us is then considered terminated. All returned checks will be subject to a $35.00 fee and applied to the account balance. If you have any questions regarding your bill at any time, you may contact our billing specialist at (616) 949-4340.

Signature Date

Urology Surgeons, P.C.

Medical History Form

Name_____ Date of Birth_____

The following information will assist us in providing you the most excellent care. This information is a confidential record. ***Please fill out all three pages of these forms completely.***

History of Present illness: Please answer the following questions

- What is the main reason for your visit? (Describe your problem in detail) _____

  _____

  _____
- Location of the problem: ☐ Abdomen ☐ Back ☐ Leg ☐ Pelvis ☐ Other_____
- On a scale of 1-10, with 10 being the most severe, circle the number that best describes the problem 1 2 3 4 5 6 7 8 9 10
- When did you first notice the problem: ☐ 2 days ago ☐ 2 weeks ago ☐ 1 month ago ☐ Other _____
- Does anything help or make the problem worse? ☐ Moving around ☐ Standing up ☐ Lying on side ☐ Other _____

  _____
- How long does the problem last? ☐ 30 minutes ☐ 1 hour ☐ Is it always there ☐ Other _____
- Is anything else occurring at this time: ☐ Yes ☐ No If yes, please explain: ☐ Nausea ☐ Headaches ☐ Fever Other _____
- Is the problem constant or variable ☐ Dull, then sharp ☐ Very sharp, then leaves ☐ Always there ☐ Other _____

  _____
- Does the problem interfere with your normal functions? ☐ Yes ☐ No If yes, please explain. _____

  _____

Height_____ **Weight**_____ **Gender**_____

Have you ever had the following (circle all that apply)

Anemia
Anxiety/Depression
Arthritis
Asthma
Blood clotting disorder
Cataracts
Chronic Bronchitis / COPD
Cirrhosis of Liver
Colitis
Congestive Heart Failure
Diabetes Type
Diverticulitis
DVT
Elevated Cholesterol
Emphysema
Enlarged Prostate
Epilepsy
GERD/Heartburn
Glaucoma
Gout
Heart Attack
Heart Disease
Hepatitis B or C
High Blood Pressure
Intestinal Bleeding
HIV/Immunosuppressed
Joint Replacement
Kidney Stone: when?
Kidney Disease
Kidney Infection
Liver Disease
Migraines
Pacemaker
Parkinson's Disease
Prostate Problems
Sleep Apnea / CPAP
Stroke
Thyroid Problems
Vascular Heart Disease
Cancer—NO
Cancer—YES:
What kind? _____
Treatment? _____

Other medical problems:
_____
_____
_____

Use of Blood Thinners?
Aspirin Yes / No
Plavix Yes / No
Coumadin/Warfarin Yes / No
Pradaxa Yes / No

Any of the sections that do not apply please mark with N/A

List all surgeries and procedures and approximate date

Surgery/Procedure	Year Performed	Surgery/Procedure	Year Performed

List all prescription and over-the-counter medications and supplements you take regularly –attach separate sheet if needed

Medication	Dose	Frequency (how often)	Prescribing Physician (or over the counter)

List all medication allergies and the reaction you had when you took them

Allergic To:	Reaction	Allergic To:	Reaction

Family History *Are You Adopted? NO YES*

Has any blood relative had any of the following? *Indicate "M" for mother's side, "P" for father's side or if other family member*

Problem	Family Member	Age Onset	Problem	Family Member	Age Onset
Blood Disorder			Kidney Stones		
Cancer-what kind			Heart Disease		
Prostate Cancer			Blood Clotting disorder		
Testicular Cancer			Hypertension		
Bladder Cancer			Kidney Disease		
Kidney Cancer			Other		

Women Only

Menopause YES, since age _____
NO: First day of most recent menstrual period: _____
How many pregnancies have you had? _____
Are you currently pregnant? NO / YES

Vaginal Delivery? #_____C-section? #_____
Current birth control?_____
Any hormone replacement? _____
Are you sexually active? YES / NO

Men Only

History of erectile dysfunction? NO / YES, how long ?_____days /months / years
Any previous treatments: _____
Are you sexually active? YES / NO

Social History

What is your occupation? _____
Marital status: Single Engaged Married Divorced Widowed
Do you use tobacco products? Never / Former- when quit? _____ / Yes—how much per day/week? _____
Do you drink alcohol? Never / Former- when quit? _____ / Yes—how much per day/week? _____
Do you use illegal drugs? Never / Former- when quit? _____ / Yes—how much per day/week? _____
Do you drink caffeine? Never / Former- when quit? _____ / Yes—how much per day? _____
How much exercise do you get? Sedentary 1-2 times/mo 1-2 times/wk 3-4 times/wk nearly every day daily
Have you ever been exposed to harmful chemicals at work or elsewhere? NO YES (explain) _____

Please circle any symptoms you are *currently* having, or have had *recently*:

CONSTITUTIONAL
Fever
Chills
Headache
Weight change past 3 months
Gain: How much
Loss: How much

EYES
Blurred vision
Double vision
Eye pain

EAR/NOSE/THROAT
Ear infection
Sore throat
Sinus Problem

CARDIOVASCULAR
Chest pain
Irregular heart beat

RESPIRATORY
Wheezing
Frequent cough
Shortness of breath

GASTROINTESTINAL
Abdominal pain
Nausea/vomiting
Indigestion/heartburn
Constipation
Diarrhea

GENITOURINARY
Nighttime Frequency
Daytime Frequency
Burning/painful urination
Delayed/weak stream
Brown, black urine
Bloody urine
Involuntary loss of urine/Dribbling

SKIN
Rash
Boils
Persistent itching

NEUROLOGIC
Tremors
Dizzy spells
Numbness/tingling

MUSCULOSKELETAL
Joint pain
Neck pain
Back pain

ENDOCRINE
Excessive thirst
Heat intolerance
Cold intolerance
Decreased libido

PSYCHOLOGIC
Generally dissatisfied with life
Depression
Considered suicide

HEME-LYMPH
Easy bleeding
Easy bruising
Swollen glands

ALLERGY/IMMUNE
Seasonal allergies

1000 E. Paris S.E., Suite 230
Grand Rapids, MI 49546
Tel: (616) 949-4340
Fax: (616) 949-4341

RANDALL S. KUNTZMAN, M.D.
JOHN R. LOBO, M.D.
MARKIAN R. IWASZKO, M.D.
NAVNEET S. MANDER, M.D.
ANDREW L. MCELROY, M.D.
ADAM D. BEZINQUE, D.O.
NICOLE SPRATLING, N.P.

WELCOME to our practice! We appreciate the opportunity to assist you with your healthcare needs. Our staff is made up of qualified professionals, who work together as a team to bring you the highest quality health care in a warm, caring setting. We've provided this information so that we may better serve you. It contains answers to commonly asked questions. Any other questions, please feel free to contact our staff at (616) 949-4340.

OFFICE HOURS
Our office is open Monday through Friday 8:30 a.m. to 5:00 p.m. Please use entrance A or E then elevator or stairs to 2nd floor.

NEW PATIENT APPOINTMENTS
Your appointment has been scheduled for _____.
Depending upon the nature of your visit, your initial appointment may require up to one hour of your time. We make every effort to remain on schedule for appointments. However, emergencies can put us behind and we appreciate your understanding in these situations.

If you are unable to keep your appointment, please contact our office to reschedule your appointment. We would appreciate a 24-hour notice of cancellation. There is a $50.00 charge for no show of an appointment which is not billable to your insurance.

In an effort to expedite your time spent in our office, **we would ask that you arrive 15 minutes prior to your scheduled appointment.** We have enclosed a pre-registration form and medical history form for you to complete **prior** to your appointment. Please bring these completed forms and your health insurance cards with you to the appointment. All information provided to us is considered confidential.

Below are some of the insurances with which we currently participate with:

BCBS (most policies)	Aetna	Cigna
Blue Care Network	Humana	State of MI Medicaid
Medicare	Auto	Priority Health
United Healthcare	Coventry	ASR/Physician Care
Medicare Advantages	First Health	PHCS
Workers Compensation	RR Medicare	Molina (most policies)

If you have an HMO or Medicaid product, it is **your responsibility** to contact your primary care physician for an insurance authorization to see us. If you arrive to our office without an authorization when required, we reserve the right to cancel your appointment until an authorization is received or to ask for payment in advance for the visit. **Copays** are due at time of service. If you don't have insurance payment is required at appointment. If you have any questions about our billing policies, please call the office.

Please fill out forms and bring them to your appointment.
We are a PRIVATE PRACTICE, so our Providers need these forms.

PATIENT REGISTRATION FORM

(PLEASE FILL OUT COMPLETELY)

PATIENT INFORMATION

Last Name	First Name		MI
Social Security #	Address		Apt#
City	State		Zip
Primary Phone (Circle one: Home, Cell, Work)	Home Phone	Work	Cell
Date of Birth ☐Male ☐Female	Race American Indian-Alaska Native / Nat Hawaiian -Pacific Black-African American / White / Asian		Ethnicity Hispanic or Latino Not Hispanic or Latino
Are you married? ☐ Yes ☐ No	Spouse's Name		
Do you have a primary doctor? ☐ Yes ☐ No	If yes, First and Last Name of primary doctor:		Primary Care Phone Number
Did this doctor refer you? ☐ Yes ☐ No	If no, First and Last Name of referring doctor:		

INSURANCE INFORMATION

Primary Insurance Company	**Contract Number**	**COPAY:**
Subscriber's First and Last Name	Date of Birth	Social Security#
Relationship to Patient	Employer	
Secondary Insurance Company	**Contract Number**	
Subscriber's First and Last Name	Date of Birth	Social Security#
Relationship to Patient	Employer	
Tertiary Insurance Company	**Contract Number**	
Subscriber's First and Last Name	Date of Birth	Social Security#
Relationship to Patient	Employer	

CONTACT INFORMATION

Employer		
Emergency Contact	Relationship to Patient	Phone Number
Preferred Method of Communication For Appointment Confirmation (Circle one: Home Phone, Cell, Email, Text)		
PREFERRED PHARMACY	**PHARMACY PHONE #**	

I hereby authorize payment to UROLOGY Surgeons, P.C., for medical services rendered to me or others covered by my insurance policy. I authorize the release of such information as may be necessary for the billing office to file claim(s) for payment. I acknowledge financial responsibility for charges not covered under my insurance policy and any services not authorized by my Primary Care Physician. I authorize UROLOGY Surgeons to give me responsible and proper medical care by today's standards.

Patient's Signature: Date:_____