UROLOGY SURGEONS, P.C.
RELEASE OF INFORMATION CONSENT

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 ______________________
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 and Discover as well as personal checks, money orders, debit cards and cash.

**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, it should be understood that 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 and Discover.

**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) 988-8646

---

**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 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
- Use of Blood Thinners?
- Aspirin Yes / No
- Plavix Yes / No
- Coumadin/Warfarin Yes / No
- Pradaxa Yes / No
- What kind? ______________
- Treatment? ______________
- Other medical problems: ____________________________

- Kidney Stone: when?
Any of the sections that do not apply please mark with N/A

List all surgeries and procedures and approximate date

<table>
<thead>
<tr>
<th>Surgery/Procedure</th>
<th>Year Performed</th>
<th>Surgery/Procedure</th>
<th>Year Performed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dose</th>
<th>Frequency (how often)</th>
<th>Prescribing Physician (or over the counter)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Allergic To:</th>
<th>Reaction</th>
<th>Allergic To:</th>
<th>Reaction</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Problem</th>
<th>Family Member</th>
<th>Age Onset</th>
<th>Problem</th>
<th>Family Member</th>
<th>Age Onset</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood Disorder</td>
<td></td>
<td></td>
<td>Kidney Stones</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancer-what kind</td>
<td></td>
<td></td>
<td>Heart Disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prostate Cancer</td>
<td></td>
<td></td>
<td>Blood Clotting disorder</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Testicular Cancer</td>
<td></td>
<td></td>
<td>Hypertension</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bladder Cancer</td>
<td></td>
<td></td>
<td>Kidney Disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kidney Cancer</td>
<td></td>
<td></td>
<td>Other</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Women Only

Menopause  YES, since age ______  Vaginal Delivery? #______ C-section? #______
NO: First day of most recent menstrual period: ________  Current birth control?  ______________________
How many pregnancies have you had? ______  Any hormone replacement?  ______________________
Are you currently pregnant? NO / YES  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 everyday  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
Sore throat
Sinus Problem
Fever
Chills
Headache
Weight change past 3 months
Gain: How much
Loss: How much

CARBOVASCULAR
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
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. However, if you have 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.

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. There is a $50.00 charge for no show of an appointment which is not billable to your insurance and/or if you do not give a 24 hour notice of cancellation there will be a $50.00 charge.

In an effort to expedite your time spent in our office, we would ask that you arrive fifteen 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.

BILLING PROCEDURES
Below is a listing of insurances with which we currently participate:

- Blue Cross Blue Shield of Michigan/Traditional/PPO
- Blue Choice POS
- Blue Care Network
- Grand Valley Health Plan
- Priority Health
- Actua
- CIGNA
- Medicare
- Medicaid
- United Healthcare

If you have an HMO, PPO or Medicaid product, it is your responsibility to contact your primary care physician to secure an authorization for your visits with our office. If you arrive to our office without an authorization, we reserve the right to cancel your appointment until an authorization is received or to ask for payment in advance for the visit. If you have any questions about our billing policies, please call the office.
**PATIENT REGISTRATION FORM**

*(PLEASE FILL OUT COMPLETELY)*

### PATIENT INFORMATION

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>MI</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Social Security #</th>
<th>Address</th>
<th>Apt#</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>City</th>
<th>State</th>
<th>Zip</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Primary Phone (Circle one: Home, Cell, Work)</th>
<th>Home Phone</th>
<th>Work</th>
<th>Cell</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date of Birth</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Race</th>
<th>Ethnicity</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- American Indian-Alaska Native / Nat Hawaiian-Pacific
- Black-African American / White / Asian
- Hispanic or Latino
- Not Hispanic or Latino

<table>
<thead>
<tr>
<th>Are you married?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Do you have a primary doctor?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Did this doctor refer you?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### INSURANCE INFORMATION

<table>
<thead>
<tr>
<th>Primary Insurance Company</th>
<th>Contract Number</th>
<th>COPAY:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Subscriber’s First and Last Name</th>
<th>Date of Birth</th>
<th>Social Security#</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Relationship to Patient</th>
<th>Employer</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Secondary Insurance Company</th>
<th>Contract Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Subscriber’s First and Last Name</th>
<th>Date of Birth</th>
<th>Social Security#</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Relationship to Patient</th>
<th>Employer</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Tertiary Insurance Company</th>
<th>Contract Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Subscriber’s First and Last Name</th>
<th>Date of Birth</th>
<th>Social Security#</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Relationship to Patient</th>
<th>Employer</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### CONTACT INFORMATION

### PREFERRED PHARMACY

<table>
<thead>
<tr>
<th>Employer</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Emergency Contact</th>
<th>Relationship to Patient</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Preferred Method of Communication For Appointment Confirmation** *(Circle one: Home Phone, Cell, Email, Text)*

### 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: ____________________________