

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

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) |
|------------|------|-----------------------|---|
| | | | |
| | | | |
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| | | | |

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 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 | Diarrhea | NEUROLOGIC | Generally dissatisfied with life |
| Fever | Sinus Problem | GENITOURINARY | Tremors | Depression |
| Chills | CARDIOVASCULAR | Nighttime Frequency | Dizzy spells | Considered suicide |
| Headache | Chest pain | Daytime Frequency | Numbness/tingling | HEME-LYMPH |
| Weight change past 3 months | Irregular heart beat | Burning/painful urination | MUSCULOSKELETAL | Easy bleeding |
| Gain: How much | RESPIRATORY | Delayed/weak stream | Joint pain | Easy bruising |
| Loss: How much | Wheezing | Brown, black urine | Neck pain | Swollen glands |
| EYES | Frequent cough | Bloody urine | Back pain | ALLERGY/IMMUNE |
| Blurred vision | Shortness of breath | Involuntary loss of urine/Dribbling | ENDOCRINE | Seasonal allergies |
| Double vision | GASTROINTESTINAL | SKIN | Excessive thirst | |
| Eye pain | Abdominal pain | Rash | Heat intolerance | |
| EAR/NOSE/THROAT | Nausea/vomiting | Boils | Cold intolerance | |
| Ear infection | Indigestion/heartburn | Persistent itching | Decreased libido | |
| | Constipation | | PSYCHOLOGIC | |



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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 elevators 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 | Confinity/PPOM | ASR/Physician Care |
| Medicare Advantages | First Health | PHCS |
| Workers Compensation | RR Medicare | Molina (most policies) |
| Meridian (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.

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 | <input type="checkbox"/> Male <input type="checkbox"/> Female | Race <small>American Indian-Alaska Native / Nat Hawaiian -Pacific Black-African American / White / Asian</small> | | Ethnicity <small>Hispanic or Latino Not Hispanic or Latino</small> |
| Are you married? <input type="checkbox"/> Yes <input type="checkbox"/> No | | Spouse's Name | | |
| Do you have a primary doctor? <input type="checkbox"/> Yes <input type="checkbox"/> No | | If yes, First and Last Name of primary doctor: | | Primary Care Phone Number |
| Did this doctor refer you? <input type="checkbox"/> Yes <input type="checkbox"/> 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: _____