

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 PC FINANCIAL POLICY

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. 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 office visit appointment, we kindly ask for at least 24-hour notice to avoid a fee. If you must change your hospital surgery appointment, we kindly ask for at least 48-hour notice to avoid a fee.**

No Show/Late Cancellation Fees:

Office Visit - \$50

Office Procedure - \$100

Hospital Surgery - \$200

Preauthorization for second surgical opinion is becoming a requirement for many insurance companies. When a surgery or procedure (MRI scans, CT scans, outpatient surgery) is scheduled, please contact your insurance company immediately to determine if preauthorization is necessary before the surgery or procedure. You will need to initiate communication with the insurance company. Your insurance company can deny 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 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 of scheduling. 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.

Cash Patients: Payment is expected at the time of scheduling.

Patient Responsibility: Any unpaid balance 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) 483-7359.

Our office uses an off-site billing company. If your email address is on file, you will receive your billing statement via email from Anodyne. If you prefer a paper billing statement, a \$2 fee will be charged. If you have billing questions, you may contact Plutus Health Inc at 616-483-7359 or billing@urologysurgeons.com

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	Use of Blood Thinners?
Cirrhosis of Liver	Heart Disease	Sleep Apnea / CPAP	Aspirin Yes / No
Colitis	Hepatitis B or C	Stroke	Plavix Yes / No
Congestive Heart Failure	High Blood Pressure	Thyroid Problems	Coumadin/Warfarin Yes / No
Diabetes Type	Intestinal Bleeding	Vascular Heart Disease	Pradaxa Yes / No
Diverticulitis	HIV/Immunosuppressed	Cancer—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)

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

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



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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 of 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 to Friday from 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 require a 24-hour notice of cancellation for office visits. There is a \$50.00 charge for no show or less than 24hr cancellation of an appointment which is not billable to your insurance.

Please arrive 15 minutes prior to your scheduled appointment time. 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 at our office without 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 upon scheduling. If you have any questions about our billing policies, please call the office.

Please fill out ALL forms and bring them to your appointment.

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