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Patient Information

Date: _____

Patient Name (Last, First, Middle Initial): _____

Local Address: _____

City: _____ State: _____ Zip: _____

☐ Male ☐ Female Social Security #: _____

Birth Date: _____ / _____ / _____ Age: _____

Local Phone: (_____) _____ Cellular Phone: (_____) _____

Email Address: _____

Home Away Address: _____

City: _____ State: _____ Zip: _____

Away Phone: (_____) _____

Patient's Employer: _____ Work Phone: (_____) _____

Marital Status: _____ Spouse's Name: _____

Spouse's Employer: _____ Work Phone: _____ (_____)

Spouse's Social Security #: _____ Spouse's Birth Date: _____/_____/_____

Nearest relative not living with you: _____ Phone: (_____) _____

Whom may we contact in case of emergency?: _____

Phone: (_____) _____

Who is your primary physician?: _____ Phone: (_____) _____

Your preferred pharmacy: _____ Phone: (_____) _____

New Policy for Notification of Test Results

Due to federal guidelines, the practice is implementing a policy for notifying our patients about their test results.

Call Home # _____ Work # _____ Phone # _____

Please check the following which apply:

☐ I approve you to leave message on answering machine or voice mail.

☐ I approve you to leave message with person answering the phone.

This authorization will be valid until we receive further notification from you.

Patient's Signature: _____ ***Date:*** _____

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Patient Information *(cont.)*

Consent For Use And Disclosure Of Health Information

In addition to the authorization for release a my Protected Health Information, I furthermore acknowledge that I have the right to authorize access and disclosure of my Protected Health Information (PHI) to anyone of my choosing for billing, condition, treatment and prognosis to the following individual(s):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I request the following restriction(s) to releasing my PHI: _____

_____

_____

_____

I understand that I am entitled to a copy of Encore Urology's Notice of Privacy Practices. I can access a copy of the Notice of Privacy Practices from the website (www.encoreurology.com) or from the office directly.

I understand that I have the right to revoke this authorization, in writing, at anytime. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. Unless otherwise revoked this authorization shall be in force and effect one year from today's date at which time this authorization expires.

Patient's Signature: _____ ***Date:*** _____

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Patient Information *(cont.)*

Responsible Party Information

Name: _____

Phone: (_____) _____

Address: _____

City: _____ State: ____ Zip: _____

Relationship with Patient: _____

Responsible Person SS#: _____-_____-_____ DOB: _____ / _____ / _____

Employer's Name: _____

Phone: (_____) _____

Address: _____

City: _____ State: ____ Zip: _____

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay a fixed allowance for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductable amount, co-insurance, and other balance not paid for by your insurance company.

Method of Payment: ☐ Cash ☐ Check ☐ Credit Card

If payment is not made in full, I agree to pay all costs of collection, including attorney fees. I authorize Encore Urology to furnish information to all insurance carriers concerning my illness and treatment and I hereby assign to Encore Urology all payment for medical services rendered to me (the patient) or my dependents, in the event an insurance claim is filed by the practice. I further agree that a photocopy of this agreement shall be as valid as the original.

Patient's Signature: _____ ***Date:*** _____

Parent/Guardian Signature (if minor): _____

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Medical History

Date: _____

Patient Full Name: _____ Age: _____

Please describe the reason for your appointment: _____

_____

Medical History:

Do you currently suffer from any othe following (check all those that apply)?

- ☐ Arthritis
- ☐ Asthma
- ☐ Bladder Problems
- ☐ Cataracts of the Eyes
- ☐ Chronic Bleeding Problems
- ☐ Chronic Lung Disease
- ☐ Diabetes Mellitus
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Prostate Problems
- ☐ Stomach Ulcers
- ☐ Other: _____

Past Surgical History:

Please check the surgical procedures which you have had done in the past.

- ☐ Angioplasty
- ☐ Appendectomy
- ☐ Artificial Joint Implant
  Type: _____
- ☐ Bladder Surgery
  Type: _____
- ☐ Colonoscopy
  Year: _____
- ☐ Gall Bladder Removal
- ☐ Hysterectomy
- ☐ Open Heart Surgery
- ☐ Pacemaker Implanted
- ☐ Prostate Surgery
  Type: _____

Additional Surgeries: _____

_____

_____

Vaccine:

- ☐ Pneumococcal vaccine – Year: _____

(Continued on the other side.)

Allergies:

Please check any medications to which you are allergic.

- ☐ None
- ☐ Antidepressants
- ☐ Blood Pressure Medication
- ☐ Codiene
- ☐ Compazine
- ☐ Hydrocodone
- ☐ Iodine
- ☐ Morphine
- ☐ Penicillin
- ☐ Phenergan

Family Medical History:

Please check the boxes of any diseases which may run in your family.

- ☐ Aneurysms
- ☐ Bladder Cancer
- ☐ Colon Cancer
- ☐ Kidney Cancer
- ☐ Kidney Stones
- ☐ Prostate Cancer

Social History:

Do you smoke? ☐ Yes ☐ No

If yes, how many packs per day? _____

If no, did you ever smoke? ☐ Yes ☐ No

If you no longer smoke, but indicated that at one time you did smoke, when did you quit (year)? _____

Do you consume alcoholic beverages? ☐ Yes ☐ No

If yes, how many drinks per day (on average)? _____

If no, did you ever drink? ☐ Yes ☐ No

If you no longer drink alcohol, but indicated that at one time you did, when did you quit (year)? _____

Occupational History:

Please check the box that currently applies. If you are currently working, please include your job title.

- ☐ Retired
- ☐ Currently Working: _____

Medications:

Please list all current medications you take (you do not have to list what you take it for). If you are not on any medications, just check the box 'No Medications'.

- ☐ No Medications

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

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Receipt of Notice of Privacy Practices

Written Acknowledgement Form

Date: _____

I, _____ , have received a copy of Encore
(please print patient's name)

Urology's Notice of Privacy Practices.

*Signature:*_____

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Review of Systems

Date: _____

Patient Full Name: _____

Do you currently have *or* have you had any of the following symptoms?

	YES	NO
Cardiovascular		
A-FIB:	☐	☐
Angina:	☐	☐
Beats Fast:	☐	☐
Blood Clots:	☐	☐
Bruises Easily:	☐	☐
Defibulator (provide card):	☐	☐
Elevated Cholesterol:	☐	☐
Heart Attack:	☐	☐
Heart Failure:	☐	☐
High Blood Pressure:	☐	☐
Increased Bleeding:	☐	☐
Irregular Beats:	☐	☐
Murmur:	☐	☐
Pacer (provide card):	☐	☐
Sickle Cell:	☐	☐
Skipped Beats:	☐	☐
Stroke:	☐	☐
Varicose Veins:	☐	☐
Constitutional Symptoms		
Chills:	☐	☐
Cold:	☐	☐
Fever:	☐	☐
Headache:	☐	☐
Weight Loss:	☐	☐
Ear / Nose / Throat		
Ear Infection:	☐	☐
Hard of Hearing:	☐	☐
Sore Throat:	☐	☐
Sinus Problems:	☐	☐
Tinnitus:	☐	☐
Eyes		
Blurred Vision:	☐	☐
Cataracts:	☐	☐
Double Vision:	☐	☐
Macular Degeneration:	☐	☐
Pain:	☐	☐
Glaucoma:	☐	☐
Endocrine		
Cancer:	☐	☐
Diabetes:	☐	☐
Diet Controlled:	☐	☐
Insulin Controlled:	☐	☐
Thyroid Disease:	☐	☐
Gastrointestinal		
Abdominal Pain:	☐	☐
Bleeding Ulcer:	☐	☐
Cancer:	☐	☐
Gallbladder:	☐	☐
Heart Burn:	☐	☐
Hemorrhoids:	☐	☐
Hernia:	☐	☐
Indigestion:	☐	☐
Liver Disease:	☐	☐
Nausea / Vomiting:	☐	☐
Pancreatic Disease:	☐	☐
Genitourinary		
Cancer:	☐	☐
Kidney Stones:	☐	☐
Painful Urination:	☐	☐
Urgency:	☐	☐
Urinary Frequency:	☐	☐
Urinary Retention:	☐	☐
Weak Stream:	☐	☐
Hematological:		
Blood Disorder:	☐	☐
Cancer:	☐	☐
Lymphoma:	☐	☐

Do you currently have *or* have you had any of the following symptoms? (cont.)

	YES	NO
Integumentary		
Boils:	☐	☐
Cancer:	☐	☐
Persistent Itch:	☐	☐
Skin Rash:	☐	☐
Squamos Cell:	☐	☐
Musculoskeletal		
Arthritis:	☐	☐
Bone Pain:	☐	☐
Cancer:	☐	☐
Implants:	☐	☐
Joint Pain:	☐	☐
Neck Pain:	☐	☐
Jaw Pain:	☐	☐
Neurological		
Anxiety:	☐	☐
Depression:	☐	☐
Dizzy Spells:	☐	☐
Migraines:	☐	☐
Numbness / Tingling:	☐	☐
Seizures:	☐	☐
Tremors:	☐	☐

	YES	NO
Respiratory		
Asthma:	☐	☐
COPD:	☐	☐
Emphysema:	☐	☐
Frequent Cough:	☐	☐
Lung Cancer:	☐	☐
Nodules:	☐	☐
Shortness of Breath:	☐	☐
Sleep Apnea:	☐	☐
Tuberculosis:	☐	☐
Wheezing:	☐	☐
Pain		
Does your condition cause you any pain?	☐	☐

If yes, on a scale of 1–10, with 10 being the most severe, circle the number that best describes the pain:

1 2 3 4 5 6 7 8 9 10

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Lifetime Authorization

Today's Date: _____

I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers, any information needed for this or a related Medicare claim. I request that the payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization to submit to Medicare for payment.

I request that this authorization also apply to all other insurance.

Signature: _____

Title or Relationship: _____

If signed by other than the Beneficiary, state the reason the patient was unable to sign: _____

_____

_____

_____

_____

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Financial Policy

I. All patients must complete our Information and Insurance form before seeing the doctor. Please give your insurance card(s) to the receptionist for copying. If payment is not made in full, you agree to pay all costs of collection, including attorney fees.

II. PAYMENT IN FULL IS REQUIRED AT THE TIME OF SERVICE UNLESS A PRIOR ARRANGEMENT HAS BEEN MADE. We accept cash, check, Visa, MasterCard, Discover and American Express.

III. Patients under the age of 18 must be accompanied by a Parent or Guardian. The Parent or Guardian is responsible for payment at the time of service. We cannot be bound by any divorce or other family relationship contract.

IV. Any account 90 days past due will be turned over to an outside collection agency and you will be responsible for all costs of collection in addition to unpaid charges. A typical collection fee is 40% to 60% of the unpaid balance.

V. As a member of the National Credit Bureau Network, we report to all three credit agencies, Equifax, TransUnion and Experien. Prior to accepting any method of alternative payment arrangement, a full credit report may be run in order to grant credit.

VI. A $75.00 charge will be charged to your account for any check returned by the bank for any reason. We will resubmit the check for payment to the bank one time, if requested. However, if funds are still insufficient, we will not accept payments by check from you in the future.

MEDICARE

We are participating providers with Medicare. Medicare typically pays 80% of approved services. You will be responsible for the prevailing Medicare deductible and full payment of any non-covered service at the time of each visit. Non-covered services include but are not limited to: complete annual physicals, immunizations and diagnostic tests done for screening purposes.

SUPPLEMENTAL INSURANCE

Your supplemental insurance may cover the 20% not paid by Medicare. Medicare submits claims directly to some supplemental insurance carriers including those connected to their Medigap/Crossover program. We will file a claim with your insurance carrier if Medicare does not forward that claim to your supplemental insurance. If your supplemental insurance carrier does not pay the physician directly, you will be required to pay the 20% not paid my Medicare.

OUT-OF-NETWORK INSURANCE

If you have out of network insurance or non-par insurance then we do not participate with your insurance company and your bill with the physician is your responsibility and is due at the time of service. We will, as a courtesy file the claim to your insurance company for you if you furnish your insurance information. Considerable care has been taken in setting our fees. We want to assure you that our charges accurately reflect the complexity of care rendered and the skill and expertise required for your care. If your insurance company refused to accept the level of our charge, you are responsible for payment in full.

IN-NETWORK INSURANCE

We currently participate with some "Managed Care" insurance programs (Community Health Partners and Pro-America). You will be required to pay any co-pay or unfulfilled deductible for non-covered service at the time of each visit. As with any other insurance policy, if your insurance carrier has not paid your account within 90 days, the balance will automatically become due from you.

MEDICAID

We are participating providers with Medicaid. If you have a Medipass provider, your service will need to be verified with that provider prior to treatment. If you are not eligible for Medicaid benefits at the time of service, payment in full will be required. If payment is not made in full, I agree to pay all costs of collection, collections fees and court costs, including attorney fees. I authorize Encore Urology to furnish information to all insurance carriers concerning my illness and treatment and I hereby assign Encore Urology all payment for medical services rendered to me (the patient) or my dependents, in the event an insurance claim is filed by the practice. I further agree that a photocopy of this agreement shall be valid as the original.

RESPONSIBILITY FOR CHARGES

"I understand that if my insurance company denies the claim for any reason, I will promptly pay all outstanding charges. I am also fully responsible for all charges incurred if I have given incorrect insurance information or if I fail to notify Encore Urology of any changes in my insurance coverage."

RELEASE OF INFORMATION

"I authorize the release of any medical information necessary to process insurance claims associated with treatment at Encore Urology For Medicare Part-B, I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers, or the billing agent for Encore Urology any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of insurance benefits either to myself or to the party who accepts the assignment."

PRIVACY NOTICE

"I have had the opportunity to review the Notice of Privacy Practices, and I understand that I may ask questions about the Notice of Privacy Practices at any time. The receptionist will provide a copy of the Notice of Privacy Practices upon my request."

AGREEMENT TO PAY FOR SERVICES

"I agree to pay Encore Urology for all charges for services received today, and during future visits. I understand that payment in full, insurance co-payment or insurance co-insurance is required at the time that services are rendered. I am providing my credit card which I understand may be charged to pay for overdue balances. I further understand that if this account is referred to an agency, court or attorney for resolution, I will be responsible for all fees associated with collection. I also understand that if I become a patient on a payment plan who fails to complete payment plan as agreed, I will owe the balance of Encore Urology standard fees and not the balance of the discounted or fee arrangement. I also have read and agree to comply with the Encore Urology financial policy."

ASSIGNMENT OF BENEFITS

"I authorize assignment of all medical insurance benefits to the named provider for medical services received."

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay a fixed allowance for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance/co-pay, any other balance not paid for by your insurance company. It is also your responsibility to provide us with current and active insurance information.

My Method of Payment: ☐ **Cash** ☐ **Check** ☐ **Credit Card**

If you have any questions about our financial policy, please feel free to ask our billing department for clarification.

I HAVE READ AND UNDERSTAND MY FINANCIAL RESPONSIBILITIES.

Patient Signature: _____ ***Date:*** _____