Name _____ Date _____
Last First MI

Physical Address _____
911 Information County

Mailing Address (if different from above) _____

Phone _____
Home Work Cell

_____
Social Security Number Age Date of Birth Marital Status Sex

Email Address _____Preferred Language_____

Ethnicity **(check one)** ☐Hispanic/Latino ☐Non-Hispanic/Non-Latino ☐Decline to State

Race **(check one)** ☐African-American/Black ☐Native American/Alaskan Native ☐White ☐Cambodian
☐ Asian/Pacific Islander ☐Asian-Indian ☐Chinese ☐Filipino ☐Guamanian ☐Hawaiian ☐Japanese ☐Korean ☐Laotian
☐ Samoan ☐Vietnamese ☐Other_____ ☐Decline to State

Employer Name & Phone_____

Spouse's Name _____Spouse's Social Security #_____

Spouse's Employer & Phone_____

EMERGENCY CONTACT

Name of person not living with you _____

Relationship _____ Phone _____

IF PATIENT IS A MINOR

Father's Name _____

Father's Employer _____ Father's Social Security # _____

Mother's Name _____

Mother's Employer _____ Mother's Social Security # _____

MEDICAL/INSURANCE INFORMATION

Referring Doctor _____ Family Doctor_____

Insurance Company _____

Card Holder's Name & DOB _____ Relationship to Patient _____

UROLOGY ASSOCIATES OF FREDERICKSBURG

Patient History Form

Please complete the following form and answer all questions so that we may have an updated record of your medical history. Thank You.

Name: Chart#:

Today's Date: Phone#: Date of Birth:

Your appointment is with: Referring Physician:

Why are you seeing the doctor today? _____

How long have you had this problem? _____

Family History (Please indicate if any family member has had any of the following.)

Bladder Cancer		Diabetes	
Kidney Cancer		Gout	
Prostate Cancer		Heart Disease	
Kidney Stones		Hypertension	

Other: _____

Current Medications - Please list ALL medications you are currently taking including over the counter meds (Attach list if necessary)

Drug Name:	Strength	Directions

Pharmacy Name: Location: Phone #:

Allergies - Please list ALL types (Drug, seasonal, pets, environmental, foods)

Allergy	Reaction

UROLOGY ASSOCIATES OF FREDERICKSBURG

Patient History Form

Please complete the following form and answer all questions so that we may have an updated record of your medical history. Thank You.

Social History

Please provide the following information:

Marital Status: ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed

Number of Children: _____

Occupation: _____

Alchohol Consumption:

☐None ☐Yes ☐Occasional/Social # of drinks per day _____

Tobacco per day:

☐None ☐Yes ☐# of Packs/day _____# of Cigarettes/day ☐Smokeless Tobacco

If you previously stopped, when? _____

Recreational Drugs: _____

Caffeinated beverages:

☐None ☐Yes # of cups or cans/day _____

REVIEW OF SYSTEMS

Please indicate whether you are **CURRENTLY** having any of the symptoms or conditions listed below:

CONSTITUTIONAL

- Chills ☐
- Fever ☐
- Night sweats ☐

EYES

- Blindness ☐
- Cataracts ☐
- Glaucoma ☐
- Blurred vision ☐

NEUROLOGICAL

- Balance problems ☐
- Headache ☐
- Paralysis/weakness ☐

GASTROINTESTINAL

- Abdominal pain ☐
- Constipation ☐
- Irregular bowel movements ☐
- Nausea/vomiting ☐

CARDIOVASCULAR

- Chest pain ☐
- Irregular heartbeat ☐
- Swelling ☐

MUSCULOSKELETAL

- Back pain ☐
- Gout ☐

EAR/NOSE/THROAT ☐

- Deafness ☐
- Sinus problems ☐

GENITOURINARY

- Back pain ☐
- Bedwetting ☐
- Blood in urine ☐
- Dribbling ☐
- Burning on urination ☐
- Erection problems ☐

GENITOURINARY (continued)

- Flank pain ☐
- Hesitancy with stream ☐
- Kidney stones ☐
- Leaking after voiding ☐
- Painful ejaculation ☐
- Urgency ☐
- Urinary frequency ☐
- Urgency incontinence ☐
- Urine retention ☐
- Vaginal bleeding ☐
- Weak stream ☐

RESPIRATORY

- Cough ☐
- Shortness of breath ☐
- Wheezing ☐

HEMATOLOGICAL/LYMPHATIC

- Blood clotting problems ☐
- Bleeding disorder ☐

Type:_____

- Swollen glands ☐

Other

_____

_____

_____

PAST MEDICAL HISTORY

Please indicate whether you have had any of the symptoms or conditions listed below:

CARDIOVASCULAR

- Anemia ☐
- Angina ☐
- Aortic aneurysm ☐
- Arrhythmia ☐
- Atrial fibrillation ☐
- Bleeding disorder ☐

Type:_____

- Congestive heart failure ☐
- Coronary artery disease ☐
- Deep vein thrombosis ☐
- Enlarged heart ☐
- Heart attack ☐

When:_____

- Heart disease ☐
- Heart murmur ☐
- Heart valve problem ☐
- Hypertension ☐
- Sickle cell anemia ☐
- Stroke ☐
- Thrombophlebitis ☐
- Varicose veins ☐

Other:_____

ENDOCRINE

- Diabetes, non-insulin dependent ☐
- Diabetes, insulin dependent ☐
- Gout ☐
- Hyperthyroidism ☐
- Hypothyroidism ☐

Other:_____

GENERAL

- Lipid disorder/high cholesterol ☐
- Sleep apnea ☐

Other:_____

GASTROINTESTINAL

- Gallstones ☐
- Colon disease ☐

Type:_____

- ☐
- Constipation ☐
- Crohn's disease ☐
- Diverticulosis ☐
- GERD/reflux ☐
- Hepatic failure/jaundice ☐
- Hepatitis ☐

Type:_____

- ☐
- Hiatal hernia ☐
- Liver disease ☐
- Pancreatitis ☐
- Stomach ulcer ☐

Other:_____

GENITOURINARY

- AIDS/HIV ☐
- Bladder cancer ☐
- Bladder outlet obstruction ☐
- Bladder stone ☐
- Chronic kidney disease ☐
- Hematuria ☐
- Impotence/ED ☐
- Interstitial cystitis ☐
- Irradiation therapy ☐
- Kidney cancer ☐
- Kidney infection ☐
- Kidney stones ☐
- Libido decreased ☐
- Neurogenic bladder ☐
- Testicle infections ☐
- Polycystic kidney disease ☐
- Prostate cancer ☐
- Recurrent UTI ☐
- Testicular cancer ☐
- Transplant recipient ☐
- Ureter cancer ☐
- Undescended testicle ☐

Other:_____

PAST MEDICAL HISTORY

Please indicate whether you have had any of the symptoms or conditions listed below:

GYN/OB

Menopause ☐
Osteoporosis ☐
Uterine fibroids ☐
Other:_____

HEENT

Blindness ☐
Cataracts ☐
Deafness ☐
Glaucoma ☐
Other:_____

MUSCULOSKELETAL

Arthritis ☐
Back pain ☐
Claudication ☐
Fibromyalgia ☐
Other:_____

NEUROLOGICAL/PSYCHOLOGICAL

Alcoholism ☐
Alzheimer's disease ☐
Anxiety ☐
Bi-polar disorder ☐
Depression ☐
Eating disorder ☐
Epilepsy ☐
Herniated disc ☐
Migraine ☐
Multiple sclerosis ☐
Parkinson's ☐
Spinal cord injury ☐
Stroke ☐
Suicide attempt ☐
Other:_____

RESPIRATORY

Asthma ☐
COPD ☐
Emphysema ☐
Pneumonia ☐
Pulmonary Embolism ☐
Tuberculosis ☐
Other:_____

TUMORS

Breast Cancer ☐
Cervical cancer ☐
Colon cancer ☐
Gastric cancer ☐
Liver cancer ☐
Lung cancer ☐
Lymphoma ☐
Melanoma ☐
Ovarian cancer ☐
Pancreatic cancer ☐
Rectal cancer ☐
Uterine cancer ☐
Other:_____

Did you receive chemo? ☐
Finish Date:_____

Did you receive radiation therapy? ☐
Finish Date:_____

SURGERY HISTORY

(Please indicate whether you have had any of the following surgeries and the date of surgery.)

CARDIOVASCULAR

		Date
Angioplasty	☐	
Aortic aneurysm repair	☐	
CABG	☐	
Carotid artery surgery	☐	
Heart surgery	☐	
Heart surgery (stents)	☐	
Pacemaker insertion	☐	
Heart transplant	☐	
Pacemaker insertion	☐	

GENERAL

Brain Surgery	☐	
Lymphatic node dissection	☐	
Parathyroidectomy	☐	

GASTROINTETSTINAL

Appendectomy	☐	
Bowel resection	☐	
Endoscopy	☐	
Cholecystectomy (gallbladder removed)	☐	
Gastric bypass	☐	
Hemorroidectomy	☐	
Ileostomy	☐	
Inguinal hernia repair	☐	
Laparoscopy	☐	
Liver surgery	☐	
Liver transplant	☐	
Lysis of adhesions	☐	
Nissen fundoplication	☐	
Splenectomy	☐	
Stomach surgery	☐	
Umbilical hernia repair	☐	

GENITOURINARY

Bladder Surgery	☐	
Type:_____		
Biopsy of prostate	☐	
Brachytherapy (seeds)	☐	
Circumcision	☐	
Cystectomy	☐	
Cystoscopy	☐	

GENITOURINARY (continued)

		Date
Cystoscopy-dilation	☐	
Cystoscopy-stent placement	☐	
Epididymectomy	☐	
ESWL	☐	
Hydrocelectomy	☐	
Indigo laser surgery	☐	
Interstim	☐	
Kidney stone	☐	
Laser lithotripsy	☐	
Meatotomy	☐	
Nephrectomy (kidney removed)	☐	
Nephrolithotomy	☐	
Orchiectomy	☐	
Orchipexy	☐	
Penile implant	☐	
Penile surgery	☐	
Pessary	☐	
Prostate radiation	☐	
Pyeloplasty	☐	
Penile surgery	☐	
Pyeloplasty	☐	
Radical Prostatectomy	☐	
Renal transplant	☐	
Spermatocelectomy	☐	
Supra pubic catheter	☐	
TURBT	☐	
TUR prostate	☐	
Ureteroscopy	☐	
Variocelectomy	☐	
Vasectomy	☐	

GYN

Breast lumpectomy	☐	
Cystocele repair	☐	
Sling (TOT/TVT)	☐	
C-Section	☐	
Hysterectomy	☐	
Mastectomy	☐	
Tubil ligation	☐	
D&C	☐	
Botox/Collagen/Macro-plastique	☐	

SURGERY HISTORY

(Please indicate whether you have had any of the following surgeries and the date of surgery.)

HEENT		Date
Cataract surgery	☐	______
Corneal surgery	☐	______
Ear surgery	☐	______
Eye surgery	☐	______
Facial surgery	☐	______
Mastoid surgery	☐	______
Nasal surgery	☐	______
PE Tubes	☐	______
Septoplasty	☐	______
Sinus surgery	☐	______
Tonsil surgery	☐	______
Thyroid surgery	☐	______
TMJ surgery	☐	______
MUSCULOSKELETAL		
Amputation	☐	______
Back surgery	☐	______
Carpal tunnel surgery	☐	______
Cervical spine surgery	☐	______
Disc surgery	☐	______
Foot surgery	☐	______
Hand surgery	☐	______
Hip surgery	☐	______
Knee surgery	☐	______
Leg surgery	☐	______
Shoulder surgery	☐	______
RESPIRATORY		
Lung surgery	☐	______
SKIN		
Basal cell carcinoma	☐	______
Melanoma	☐	______
Squamous cell carcinoma	☐	______

OTHER	Date
______________	______
______________	______
______________	______
______________	______
______________	______
______________	______
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UROLOGY ASSOCIATES OF FREDERICKSBURG

NOTICE OF PRIVACY PRACTICES

As required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and modified by the HIPAA Omnibus Final Rule of 2013

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT OF THIS PRACTICE) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.

A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your individually identifiable health information, also described as "protected health information (PHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. Some of these records may be on paper and some may be in electronic media. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI. By federal and state law, we must follow the terms of the notice of privacy practices that we are in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your PHI
- Your privacy rights in your PHI
- Our obligations concerning the use and disclosure of your PHI

The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

Urology Associates of Fredericksburg/Privacy Officer
1051 Care Way
Fredericksburg, VA 22401
540-374-3131

C. WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION (PHI) IN THE FOLLOWING WAYS (SUBJECT TO CERTAIN RESTRICTIONS THAT YOU HAVE THE RIGHT TO REQUEST AND WE MAY GRANT)

The following categories describe the different ways in which we may use and disclose your PHI.

1. Treatment. Our practice may use your PHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your PHI in order to write a prescription for you, or we might disclose your PHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice – including, but not limited to, our doctors and nurses – may use or disclose your PHI in order to treat you or to assist others in your treatment.

2. Payment. Our practice may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment.

3. Disclosures Required By Law. Our practice will use and disclose your PHI when we are required to do so by federal, state or local law.

D. USE AND DISCLOSURE OF YOUR PHI IN CERTAIN SPECIAL CIRCUMSTANCES

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. Public Health Risks.

2. Health Oversight Activities.

3. Notifications of Data Breaches. Our practice may use and disclose your PHI to meet the requirements under the HIPAA rules to notify you and government agencies of any data breach that could potentially result in unintended disclosures of your PHI.

4. Lawsuits and Similar Proceedings. Our practice may use and disclose your PHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding.

5. Law Enforcement. We may release PHI if authorized to do so by a law enforcement official.

6. Deceased Patients. Our practice may release PHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death.

7. Serious Threats to Health or Safety. Our practice may use and disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

8. Military. Our practice may disclose your PHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

9. National Security. Our practice may disclose your PHI to federal officials for intelligence and national security activities authorized by law.

10. Inmates. Our practice may disclose your PHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

11. Workers' Compensation. Our practice may release your PHI for workers' compensation and similar programs.

E. YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding the PHI that we maintain about you:

1. Confidential Communications. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to **Urology Associates-Privacy officer at 540-374-3131** specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate **reasonable** requests. You do not need to give a reason for your request.

2. Requesting Restrictions. You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your PHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. **We are not required to agree to your request with certain exceptions (see below).** If we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your PHI, you must make your request in writing to Urology Associates Privacy Officer **540-374-3131**. Your request must describe in a clear and concise fashion:

(a) the information you wish restricted;
(b) whether you are requesting to limit our practice's use, disclosure or both; and
(c) to whom you want the limits to apply.

You have a right to revoke such restrictions in writing to the same representative of our practice.

3. Inspection and Copies. You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. This includes your right to an electronic copy of any electronic medical records that we maintain. You may request this electronic copy be transmitted to you or to any other individual or entity that you designate. We will make reasonable efforts to transmit this electronic copy in the format you request. However, if the PHI is not readily producible in this format, we will provide your record in our standard electronic format or in hard copy. You must submit your request in writing to **Urology Associates Privacy Officer 540-374-3131** in order to inspect and/or obtain a copy of your PHI. We have 30 days to comply with your request. Our practice may charge a reasonable fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial.

4. Amendment. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to **Urology Associates Privacy Officer 540-374-3131**. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the PHI kept by or for the practice; (c) not part of the PHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

5. Accounting of Disclosures. All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your PHI, outside of those for treatment, payment or health care operations purposes.

6. Right to Notice of Data Breach. In accordance with specifications of the U. S. Department of Health and Human Services, you have the right to be notified by us of a data breach that unintentionally discloses any or all of unsecured electronic PHI to an unauthorized party.

7. Right to Restrict Disclosures of Services Paid "Out of Pocket". You have a right to forego a filing of insurance claims and restriction of disclosures to your health plan for any specific service that you pay for out of pocket. This request will be honored by us as long as the **full payment is received at the time of service.**

8. Right to a Paper Copy of This Notice. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact **Urology Associates Privacy Officer 540-374-**3131.

9. Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact **Urology Associates Privacy Officer 540-374-3131**. All complaints must be submitted in writing. **You will not be penalized for filing a complaint**.

10. Right to Provide an Authorization for Other Uses and Disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. Please note, we are required to retain records of your care.

Again, if you have any questions regarding this notice or our health information privacy policies; please contact **Urology Associates Privacy Officer 540-374-3131.**

CONSENT FORM

(For Use and Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations)

I understand that as a part of my healthcare, Urology Associates of Fredericksburg originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care and treatment. I also understand this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third party payer can verify that services billed were actually provided
- And a tool for routine healthcare operations such as assessing and reviewing the competence of healthcare professionals

I understand and have been provided with a **Notice of Information Practices** that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand the Practice reserves the right to change their notice and practices, and prior to implementation, will mail a copy of any revised notice to the address that I have provided if there is a need to use or disclose any protected health information. I also understand that I have the right to restrict as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations and that the Practice is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the Practice has already taken action in reliance thereon.

With this consent, Urology Associates of Fredericksburg may call my home or other designated location and leave a message on voice mail, or with immediate family members, or in person in reference to any items that assist the practice in carrying out **Treatment, Payment, or Healthcare Operations**, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With this consent, Urology Associates of Fredericksburg may mail to my home or other designated location any items that assist the practice in carrying out **Treatment, Payment, or Healthcare Operations**, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With this consent, Urology Associates of Fredericksburg may e-mail to me appointment reminder cards and patient statements. I have the right to request that Urology Associates of Fredericksburg restrict how it uses or discloses my **Protected Health Information** to carry out **Treatment, Payment, or Healthcare Operations**. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Urology Associates of Fredericksburg to use **Protected Health Information** to carry out my **Treatment, Payment, or Healthcare Operations**.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. **If I do not sign this consent, Urology Associates of Fredericksburg may decline to provide treatment to me.**

_____ _____

Signature Date

FINANCIAL POLICY

PAYMENT FOR SERVICE AT THE TIME SERVICES ARE RENDERED – We accept cash, personal checks, MasterCard, Visa, money orders and certified checks. Payments for elective surgery must be paid by cash, MasterCard, Visa, money order or certified checks only. Returned checks will have a $50.00 service charge and you may lose your privilege to write checks in our office. Any accounts sent to collections will be charged an appropriate collection fee.
MEDICARE: We are a participating provider with Medicare

PARTICIPATING WITH MOST MAJOR INSURANCE CARRIERS: Co-payments and deductibles must be paid at the time of service. We will only file a secondary insurance if we participate with that carrier.
NON-PARTICIPATING INSURANCE COMPANIES: Payment in full is expected when services are rendered.
REFERRALS: It is your responsibility to make sure we have a valid referral on the day of your visit. If we do not have one, you will be asked to pay balance prior to services via credit card or we can reschedule your appointment.

CHILDREN OF DIVORCED PARENTS: Payment is due at the time of service no matter who is responsible by the order of the divorce decree.

WORKERS' COMPENSATION: We will file your Workers' Compensation claim for you only if the following information is provided. We need your claim number, the contact person's full name and telephone number and the address where the claim is to be processed. If it is determined by Worker's Compensation that your claim is not approved, you agree to pay the usual and customary fees for the services rendered to you in this case.
We must emphasize that as your medical care provider, our relationship and concern is with your health, not your insurance company. ALL CHARGES ARE YOUR RESPONSIBILITY FROM THE DATE SERVICES ARE RENDERED. For any balance on your account after 90 days, including those that insurance has not paid, collection action will be taken. We realize that emergencies do arise and may affect timely payment of your account. If such extreme cases do occur, please contact us promptly for assistance in the management of your account. If it becomes necessary to collect any sum due, through an attorney or collection agency, then the patient/guarantor agrees to pay all reasonable costs of collection, including attorney's fees, whether suit is filed or not. If you have any questions about the above information or any uncertainty regarding insurance coverage, please do not hesitate to ask us, we are here to help you.
Some insurance companies will not cover diagnosis and treatment of erectile dysfunction. If ED is non-covered by your insurance company, you agree to pay all charges incurred on visits for ED.
I have read and understand the above Financial Policy and agree to abide by its stipulations.

1. I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS MY INSURANCE CLAIM.
2. I AUTHORIZE AND REQUEST PAYMENT OF MEDICAL BENEFITS TO BE PAID DIRECTLY TO MY PHYSICIANS, UNLESS PAID IN FULL BY ME.
3. I AGREE THAT THIS AUTHORIZATION WILL COVER ALL MEDICAL SERVICES RENDERED UNTIL SUCH AUTHORIZATION IS REVOKED BY ME.
4. I AGREE THAT A PHOTOCOPY OF THIS FORM MAY BE USED IN LIEU OF THE ORIGINAL.

_____ _____

Signature Date

Urology Associates of Fredericksburg

Our practice strives to provide state of the art care to all of our patients. We realize how valuable your time is and we make every effort to honor your scheduled appointment time.

Due to the nature of our practice both here and the hospital, there may be times when a physician is running late. Our staff will do their best to keep you informed if this occurs. On a rare occasion it may require us to reschedule your appointment and we do our utmost to do so at a convenient time. We ask for your patience and understanding when these situations arise.

We appreciate each of our patients and we are proud to welcome you to our practice.

****

I, _____ authorize the release of my medical information by phone, fax or in person including prescription pickup to _____.

My relationship to this person is:

Spouse ☐

Child ☐

Other _____

Please list below by name and relationship any additional person you are giving this authorization to.

_____

_____

This release will remain in effect until it is revoked in writing by the patient.

Patient Signature: _____

Date: _____