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

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: _____

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