



UROLOGY ASSOCIATES OF FREDERICKSBURG

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 _____



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		
_____	_____		
_____	_____		
_____	_____		
_____	_____		



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:

Alcohol 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.)

<u>CARDIOVASCULAR</u>	Date	<u>GENITOURINARY (continued)</u>	Date
Angioplasty		Cystoscopy-dilation	
Aortic aneurysm repair		Cystoscopy-stent placement	
CABG		Epididymectomy	
Carotid artery surgery		ESWL	
Heart surgery		Hydrocelectomy	
Heart surgery (stents)		Indigo laser surgery	
Pacemaker insertion		Interstim	
Heart transplant		Kidney stone	
Pacemaker insertion		Laser lithotripsy	
		Meatotomy	
<u>GENERAL</u>		Nephrectomy	
Brain Surgery		(kidney removed)	
Lymphatic node dissection		Nephrolithotomy	
Parathyroidectomy		Orchiectomy	
		Orchipexy	
<u>GASTROINTESTINAL</u>		Penile implant	
Appendectomy		Penile surgery	
Bowel resection		Pessary	
Endoscopy		Prostate radiation	
Cholecystectomy		Pyeloplasty	
(gallbladder removed)		Penile surgery	
Gastric bypass		Pyeloplasty	
Hemorrhoidectomy		Radical Prostatectomy	
Ileostomy		Renal transplant	
Inguinal hernia repair		Spermatocelectomy	
Laparoscopy		Supra pubic catheter	
Liver surgery		TURBT	
Liver transplant		TUR prostate	
Lysis of adhesions		Ureteroscopy	
Nissen fundoplication		Variocelectomy	
Splenectomy		Vasectomy	
Stomach surgery			
Umbilical hernia repair		<u>GYN</u>	
		Breast lumpectomy	
<u>GENITOURINARY</u>		Cystocele repair	
Bladder Surgery		Sling (TOT/TVT)	
Type: _____		C-Section	
Biopsy of prostate		Hysterectomy	
Brachytherapy (seeds)		Mastectomy	
Circumcision		Tubal ligation	
Cystectomy		D&C	
Cystoscopy		Botox/Collagen/Macro-plastique	

SURGERY HISTORY

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

<u>HEENT</u>	Date	<u>OTHER</u>	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			
 <u>MUSCULOSKELETAL</u>			
Amputation			
Back surgery			
Carpal tunnel surgery			
Cervical spine surgery			
Disc surgery			
Foot surgery			
Hand surgery			
Hip surgery			
Knee surgery			
Leg surgery			
Shoulder surgery			
 <u>RESPIRATORY</u>			
Lung surgery			
 <u>SKIN</u>			
Basal cell carcinoma			
Melanoma			
Squamous cell carcinoma			

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

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: _____

Patient Name: _____ Date of Birth: _____

FINANCIAL POLICY NOTICE

Please read carefully and initial on each line to indicate you understand our policy.

_____ Insurance co- pays are due at the time of service and before you see the doctor. If you are unable to pay your co- pay you will be asked to reschedule your appointment. Due to the fact that Urology Associates of Fredericksburg is a specialty practice, higher co- pays may be indicated (consult your individual insurance policy benefits for clarification).

_____ In- office procedures are typically applied by your insurance company towards your deductible, co- insurance or other out- of- pocket expense. All fees are due in advance of the procedure or surgery performed unless an alternate arrangement is made prior to your appointment date.

_____ If you have not met your deductible your payment will be due at time of your visit. All other payments of shared costs will be billed to you after your insurance has completed the processing of your claim. Payment of your bill is due upon receipt.

_____ If we do not participate with your insurance company, and your insurance plan does not provide out- of- network benefits, you will be considered a “self- pay” patient. See the Self- Pay Patient policy below. As a courtesy, we shall provide you with the information necessary to bill your insurance company.

_____ Urology Associates of Fredericksburg enforces a \$50 fee for appointments not cancelled 24 hours prior and a \$150 fee for procedures not cancelled 48 hours prior to your scheduled procedure. As a courtesy our office calls 4 days prior to an appointment to remind patients of their future appointment. This is a courtesy only and it is ultimately the patient’s responsibility to keep track of appointments made.

_____ It is the patient’s responsibility to obtain all referral/certifications from the primary care or referring physician when required by your insurance plan. Otherwise, you may be responsible for the cost of your office visit.

_____ It is the patient’s responsibility to know from whom your insurance company requires that you to obtain any labs, x- rays, or any other ancillary services. Please let your doctor’s medical assistant or nurse know so that they may schedule these services accordingly.

_____ Many insurance plans cover ancillary services (labs, x- rays, CT scans, etc.) under alternate benefits, such as higher deductible or co- insurance amounts, even additional co- pays. These additional out- of- pocket expenses are not associated with our contract/participation with your insurance company. Instead, it is simply a matter of your plan benefits. Urology Associates of Fredericksburg must comply with both contractual obligations and government regulations; thus, we cannot alter your insurance plan benefits and will bill you accordingly.

Account #

_____ If you (1) do not have insurance coverage, (2) choose not to use your insurance coverage, or (3) are seeking treatment/services that are not covered by your insurance plan, you are a “self- pay” patient. A 20% discount of our regular fees will be applied toward our office charges, and payment is required at the time of your visit. Alternate payment arrangements are available at the discretion of the billing manager (20% discount may be forfeit). Any labs or imaging done at a third-party facility does not apply towards your payment to our office. These services will be at an additional cost to you.

_____ Delinquent accounts will be referred to an outside collection agency. If your account has been referred to an outside collection agency, YOU will be responsible for any fees associated with the collection process including but not limited to: collection agency fees, attorney fees, court costs and other charges as applicable by law.

Urology Associates of Fredericksburg accepts cash, checks, MasterCard, and Visa. \$50 fee applies to all returned checks. Additional fees may apply to special financing arrangements and bad debt/collections. By signing this Financial Policy Notice you, the guarantor, acknowledge that you have read, understand and accept the above financial policy.

Guarantor/Patient Signature: _____ Date: _____

Name of Guarantor (if different from patient) _____

Account #