Name _____ Date _____
Last First MI

Physical Address _____
911 Information County

Mailing Address (if different from above) _____

Preferred 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 ☐ Asian ☐ Native American/Alaskan Native ☐ White
Other_____ ☐ Decline to State

EMERGENCY CONTACT

Name of Contact _____

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 # _____

PHYSICIAN INFORMATION

Referring Doctor _____ Family Doctor_____

PRIMARY INSURANCE INFORMATION ****MUST COMPLETE

Insurance Company _____

ID Number: _____ Group Number: _____

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

SECONDARY INSURANCE INFORMATION ****MUST COMPLETE IF APPLICABLE

Insurance Company _____

ID Number: _____ Group Number: _____

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

TERTIARY INSURANCE INFORMATION ****MUST COMPLETE IF APPLICABLE

Insurance Company _____

ID Number: _____ Group Number: _____

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	**OTHER**	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	☐	________		

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: _____

Urology Associates of Fredericksburg
Financial Form Notice

Patient Name: _____ Date of Birth: _____

Please read carefully *sign & date* 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. Since Urology Associates of Fredericksburg is a specialty practice, higher co-pays may be charged per your insurance.
- 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.
- We enforce 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 will 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 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.
- 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 or law firm, YOU will be responsible for any fees associated with the collection process including but not limited to: collection agency fees, attorney fees of 33.33%, court costs and all other charges as applicable by law.
- We accept cash, checks, MasterCard, and Visa. $50 fee applies to all returned checks.

Guarantor/Patient Signature: _____ Date: _____

Account #