UROLOGY, P.C.

5500 Pine Lake Road Lincoln, Nebraska 68516 (402) 489-8888 Fax (402) 421-1945

The physicians and staff of Urology, P.C. would like to welcome you to our facility. Please bring all completed forms with you to your appointment.

Please arrive 30 minutes prior to your appointment time, this will allow us to make your experience here more pleasant and efficient. It is important for us to meet your medical needs; therefore, we feel the following information is needed:

1) Medical information pertaining to your visit
2) List of your prescriptions or over-the-counter or herbal medications including doses
3) Lab results (urine cultures, PSA, blood work, etc.)
4) X-rays (actual films preferred)
5) Referrals or Pre-authorizations if required by your Insurance
6) All Insurance Cards (Medicare, Medicaid, etc.)
7) Photo ID (Driver's License, Military ID, etc.)

We are located on the NW corner of 56th & Pine Lake Road in Lincoln, Nebraska. If you have any further questions or concerns regarding the above information please feel free to contact us at (402) 489-8888 and we will be happy to assist you.

Please Note: Due to the unpredictability of a surgical practice, our surgeons may be called to emergency surgery during your appointment time. Under these circumstances, you will see your physician's specific Urology-trained Physician Assistant or Nurse Practitioner.

We look forward to caring for you.

Urology, P.C.

Visit us at www.lincolnurologypc.com

UROLOGY P.C. & UROLOGY SURGICAL CENTER – Patient Registration

Referring Physician: | **Today's Date**

Primary Care Physician:

PATIENT INFORMATION

Patient's LEGAL Name

Last Name:	First:	M.I.	Birth Date:	Sex: ❑ Male ❑ Female

Nickname:	Former/Maiden name(s):

Marital Status: ❑ Single ❑ Married ❑ Widowed ❑ Divorced ❑ Separated | SSN:

Street Address:	Billing Address (if different):

City	State	Zip Code	**Home Phone:** ( )
			Cell Phone: ( )

Email address:

Current Work Status: ❑ Full Time ❑ Part Time ❑ Retired ❑Disabled ❑ Not Employed

Occupation:	Employer Name Address:	Work Phone & Ext.: ( )

Current College Student: ❑ Full Time ❑ Part Time | Name of School:

PRIMARY CONTACT PERSON (SPOUSE, PARENT, SIGNIFICANT OTHER, ETC.)

Name:	Relationship:
Address:	Employer:

Home Phone: ( )	Work Phone: ( )	Cell Phone: ( )

SECONDARY CONTACT PERSON (PARENT, CHILD, NEXT OF KIN, ETC.)

Name:	Relationship:
Address:	Employer:

Home Phone: ( )	Work Phone: ( )	Cell Phone: ( )

INSURANCE COVERAGE

Is this patient a Ward of the State? ❑ Yes ❑ No | Case Manager: Phone:

Is this patient covered by insurance? ❑ Yes ❑ No **If yes, please complete appropriate insurance information below.**

MEDICARE COVERAGE (specify)	MEDICAID (WELFARE) COVERAGE
Is Medicare Primary? ❑ Yes ❑ No	Is this patient covered by Medicaid? ❑ Yes ❑ No
Medicare #	NE Total Care #
Railroad Medicare #	Wellcare #
Medicare (Hospital Only) #	UHC Community Plan #
Medicare Advantage Plan (Unicare, Secure Horizons, etc.)	
Plan Name:	
Plan # / Group #	

SUPPLEMENTAL or OTHER INSURANCE COVERAGE

Insurance Company & Address:	Primary Insurance: ❑ Yes ❑ No

Subscriber's Name	Subscriber's SSN	Subscriber's Date of Birth	Is this a Self/Individual Plan? ❑ Yes ❑ No

Policy #	Group #	Subscriber's Relationship to Patient	Subscriber's Employer

SUPPLEMENTAL or OTHER INSURANCE COVERAGE

Insurance Company & Address:	Primary Insurance: ❑ Yes ❑ No

Subscriber's Name	Subscriber's SSN	Subscriber's Date of Birth	Is this a Self/Individual Plan? ❑ Yes ❑ No

Policy #	Group #	Subscriber's Relationship to Patient	Subscriber's Employer

What is your preferred pharmacy? _____ Location _____

Race/Ethnicity (circle one): **White** **Hispanic/Latino** **Black/African American** **Asian** **Multi-Racial** **Decline to specify**

Preferred Language (circle one): **English** **Other** _____ ❑ Interpreter Required

Is this medical condition due to an accident of any kind? **YES** **NO**

If yes, was it (choose one): **Work Related** **Auto** **Home** **Other**

Do you have a Living Will or Advanced Directive (please bring a copy with you)? **YES** **NO**

Do you have a Medical Power of Attorney (please provide documentation)? **YES** **NO**

If yes, please indicate name, address & phone: _____

_____

MEDICARE PATIENTS ONLY complete information in box:

If you are not a Medicare patient, please continue below the box.

1. Are you a Veteran? **YES** **NO**

   If yes, were you referred to us by the VA? **YES** **NO**

   If yes, do you have a written referral for today? **YES** **NO**

2. Do you have a Federal Black Lung Card? **YES** **NO**

3. Do you have a Veterans FEE BASIS ID card? **YES** **NO**

4. Are you covered by a current employer's health insurance plan through you or your spouse's employer?

   YES **NO**

5. Are you entitled to Medicare because of disability or End Stage Renal Disease? **YES** **NO**

→ AUTHORIZATION TO TREAT

I authorize and direct my physician and his/her designee to provide medical services and diagnostic services for me as they deem necessary and appropriate including but not limited to services involving pathology and radiology. I understand that I have the right to receive information, to ask questions and to receive answers to my questions about my treatment plan. I also have the right to refuse treatment and to seek a second opinion.

→ ASSIGNMENT OF BENEFITS

I hereby assign all medical and/or surgical insurance benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance and any other health plans to the physician caring for me. **I understand that I am financially responsible for all allowed charges or co-insurance amounts which are not paid by my insurance company in full within 30 days of the first statement received.**

→ RELEASE OF INFORMATION TO INSURANCE COMPANY

I authorize Urology, PC and/or Urology Surgical Center to release to the Medicare carrier and/or the Insurance Carrier listed above, any information needed for this or a related claim. I permit a copy of this authorization to be used in place of the original and request payment of this claim be made directly to Urology, PC or Urology Surgical Center.

→ NEBRASKA STATE LAW REGARDING MINORS - Nebraska state law defines a minor as anyone 18 years of age and younger. These patients are required by this law to have a legal guardian present or if this is not possible, you must make prior arrangements with our office. If prior arrangements are not made, it could result in the appointment needing to be rescheduled.

→ I understand there will be a $25 fee for a no show appointment or returned check (See also Financial Policy) payable only by cash, money order, credit or debit card.

I understand that I will be responsible for all charges if the listed insurance information is not correct.

Signature_____ Date _____

Urology PC Health History

Date:	Name:	DOB:	Sex:	Ht:	Wt:

REASON FOR VISIT:	Preferred Pharmacy Name & Address:

Tobacco Use: (please circle) Never Current Former Age Quit? _____
Type: Cigarettes Cigar Pipe Smokeless How much daily? _____

Please circle YES or NO for each of the following:

Do you have high blood pressure? NO YES **Do you have diabetes?** NO YES
Do you have any heart disease (bypass, stent, surgery)? NO YES
Have you had a flu shot? NO YES When? _____ **Pneumonia Vaccination?** NO YES When?_____

List all Current Medications. Including over-the-counter, aspirin products, fish oil, inhalers and vitamins.

List all Allergies to medications and your reactions.

Allergy to Latex? NO YES **Allergy to Iodine or shell fish?** NO YES

Past Medical History: (please circle appropriate answer)

Neurological Diseases: Multiple Sclerosis Parkinson's Muscular Dystrophy None

Cancer: NO YES **Type of Cancer:**_____ **Treatment:** Surgery Chemo Radiation

Diabetes: NO YES If yes, do you take medication for this? NO YES

Arthritis: NO YES	**Asthma:** NO YES	**COPD:** NO YES
Heart Disease: NO YES	**Hepatitis / Liver Disease:** NO YES	**HIV:** NO YES
Hypertension: NO YES	**Osteoporosis:** NO YES	**Kidney Disease:** NO YES
History of Stroke or TIA: NO YES	**History of Seizure:** NO YES	**Thyroid Problems:** NO YES
Urinary or Kidney Stones: NO YES	**Pacemaker or Defibrillator:** NO YES	

Please List all Previous Surgeries and year performed.

Surgery	Year	Surgery	Year

Have you ever had a Colonoscopy? NO YES What year was it performed?_____

Family History: (Please mark those that apply with an 'X')

	Mother	Father	Brother	Sister	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Heart Disease								
Diabetes								
Hypertension								
Anesthesia problems								
Cancer (include type)								

☐ I was adopted and have no available health history.

Personal Alcohol Use: None How Much:_____ How Often:_____

Personal Caffeine Use: None How Much:_____ How Often:_____

Total Joint Replacements or been told to take antibiotics prior to surgery or dental procedures? NO YES
If yes, What joint? _____ When was surgery?_____

Heart Attack: NO YES If yes, when: _____

Congestive Heart Failure: NO YES

TMJ or difficulty opening your mouth wide: NO YES

Back or neck disorder: NO YES

Fever during surgery: NO YES

Trouble putting a breathing tube in your airway for surgery: NO YES

Do you experience any shortness of breath at rest or during exercise: NO YES

Can you walk up 2 flights of steps without having to stop and "catch your breath": NO YES

If patient is 19 or younger:

Was patient born prematurely? NO YES If yes, how many weeks early?_____
Any developmental delays as a child? NO YES

Form Completed by: _____ Date: _____

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In order to accommodate the needs and requests of our patients we have enrolled in numerous managed care insurance programs.

While we are pleased to be able to provide this service to you, it is extremely difficult for us to keep track of all the individual requirements of the plans. Each one has different stipulations regarding how often services may be rendered and, even more importantly, where those services may be performed.

Even within the same insurance company, the plans differ depending upon what type of contract your employer has negotiated.

Providing quality medical care for our patients is our primary concern. We are more than willing to provide that care within your insurance contract guidelines if you let us know at EACH time of service *exactly* what those guidelines are.

Unfortunately, if you do not inform us of any special requirement in your contract and we subsequently order services, such as lab work or hospitalization, that are not covered, we or the selected medical facility will have no choice but to bill you directly for those charges. Payment for those charges is then your responsibility.

With your cooperation and help, you should be able to receive all of the benefits offered to you, and we will be able to concentrate on caring for your medical needs.

Additionally, we will collect a co-pay as indicated on your insurance card. However, insurance policies vary and the possibility remains your insurance company may apply your charges to a deductible or require additional co-insurance to be paid by the patient. We have no control over how your claim is processed by your insurance company and any issues related to processing of claims must be addressed with your insurance carrier.

I have read and understand the office policy stated above and agree to accept responsibility as described.

Printed Name: _____

Signature: _____ Date: _____

UROLOGY, P.C./UROLOGY SURGICAL CENTER

5500 Pine Lake Road, Lincoln, NE 68516 Phone: (402) 489-8888 Fax: (402) 421-1945

FINANCIAL POLICY

We would like to take this opportunity to welcome you to our office and to assure you that Urology, P.C. / Urology Surgical Center is committed to providing you with the best possible care. Please read the following information regarding our Financial Policy.

If you have insurance coverage, as a courtesy, we will file ALL insurance claims, as long as an assignment of benefits is given to us. We participate with most of the major insurance companies. Please contact your insurance company if you have any questions regarding participation. Please remember the following regarding insurance:

- You are ultimately responsible for follow up with your insurance company regarding payment of your claim
- Your insurance is a contract between you and your insurance company
- Not all services are a covered benefit in all insurance policies
- You are responsible for any balance due on your account
- We reserve the right to pre-collect on any medical condition which may not be covered by insurance.

Please contact our billing department promptly at **402-489-8888 option 4** if you have questions or are unable to pay your bill in full within 30 days of the first statement you receive.

If you have no insurance coverage, you will be required to pay $50 at the time of your visit; you will be billed for any additional charges. Payment arrangements are made in advance with our Patient Account Manager or billing department. To assist you, we accept cash, check, MasterCard, Visa and Discover. There will be a $25 charge on all returned checks. Remember to bring the following items along with you to your appointment:

- Your current insurance card
- Co-pay required by your insurance company
- A referral from your primary care physician, if your insurance requires one

Should you desire, we can provide you an estimate of your financial obligations regarding any proposed treatment/surgery. Please contact us promptly for assistance in the management of your account. We do use outside agencies as a means of collections should we deem it necessary. If you have any questions about the above information or any uncertainty regarding insurance coverage, do not hesitate to contact us at **402-489-8888 option 4**.

THERE WILL BE A $25 FEE FOR ANY NO SHOWS WHICH MUST BE PAID PRIOR TO RESCHEDULING PAYABLE ONLY BY CASH, CREDIT OR DEBIT CARD, OR MONEY ORDER.