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

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VASECTOMY INFORMATION

You are currently scheduled for a vasectomy consult in our office; please be aware, if you want to proceed, the *scheduling* of the procedure will take place while you are here for the consultation.

We are enclosing information that you will need to request from your insurance company prior to your appointment. It is essential that you find out if sterilization is a covered benefit under your insurance plan. Since vasectomies are an elective procedure we have a policy to collect payment prior to the procedure. We will submit your insurance for you but you will be responsible for any co-insurance or deductible that may be applied. We ask that you contact your insurance company and find out the following regarding your benefits: Please obtain the name of the person you talk to at the insurance co. and the date.
Customer Service Person ______________________ Date _____________

1) Is sterilization (Vasectomy 55250) a covered benefit? Yes or No
(this is an out-patient procedure, it is NOT done in the office)

2) Is there a deductible? Yes or No
If Yes, How much is it? _________________ Have I met it for the year? ________
How much is left to be applied? ________________.

8) The vasectomy will be done in an outpatient facility; either Urology Surgical Center or at the hospital as an outpatient (not in the office). Find out if there is a different deductible that applies for an outpatient facility?

9) Is precertification required? Yes or No

You will need to find out if our physician and/or surgery center are in Network with your insurance (specify which physician you are seeing). If our Surgery Center is not in network, see which hospital in Lincoln is in Network as you may want to have the procedure scheduled there. You will also need to find out if your plan pays in-network 80%, 85% or 90%, or the percent of out-of-network ________%.

5) Payment for any co-insurance or deductible amount is due prior to surgery. These amounts are strictly an estimate based on information from your insurance company.

UPC ____________________ ASC ____________________
Urology PC Urology Surgical Center

Please bring this completed form to your appointment; we will finalize the information in patient accounts before your surgery is scheduled.

If you have further questions or concerns regarding the above information please feel free to contact our billing department at 402-489-8888 Option 4, or Ext 221

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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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.