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.)
8. Guardianship paperwork if applicable

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.

Due to liability, we are unable to assist you to or from your vehicle. Please make arrangements if you need assistance. The nature of our practice is to give our patients the utmost in care and service, please plan plenty of time for your appointment.

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

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](http://www.lincolnurologypc.com)

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| **UROLOGY P.C. & UROLOGY SURGICAL CENTER – Patient Registration** |
| **Referring Physician:** | **Today’s Date** |
| **Primary Care Physician:** |
| **Patient’s LEGAL Name PATIENT INFORMATION** |
| 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:**( ) 🞎 Primary |
| **Cell Phone:**( ) 🞎 Primary |
| 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:

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| --- | --- |
| **MEDICARE PATIENTS ONLY** | 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.**

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**List all Allergies to medications and your reactions.**

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**Allergy to Latex?** NO YES **Allergy to Iodine?** NO YES

**Past Medical History:** (please circle appropriate answer)

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| **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.**

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| --- | --- | --- | --- |
| **Surgery** | **Year** | **Surgery** | **Year** |
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**Have you ever had a Colonoscopy?** NO YES What year was it performed?

**Family History:** (Please mark those that apply with an ‘X’)

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **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.