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.

You are scheduled for an appointment regarding infertility or a condition related. This is to inform you that **your insurance may or may not cover your services**. It is your responsibility to contact your insurance company to find out if you have coverage for this condition. Many times lab is done and prescriptions or medications are given that also may not be covered. We want you to be aware that the charges for the services provided will be your responsibility if it is deemed a non-covered benefit. Regardless of your insurance coverage, **we require a $150 payment due at check-in for this appointment and future related appointments**. Please be prepared to make this payment or your appointment will be rescheduled. If you have further questions, please contact our billing department at 402-489-8888 option 4.

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 request the following information for your appointment:

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 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.

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.

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.

Select prescriptions may be dispensed at Urology, P.C.'s in-office dispensary. The in-office dispensary's hours of operation are the same as Urology, P.C.'s hours.

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

(OVER ➔)

UROLOGY, P.C./UROLOGY SURGICAL CENTER FINANCIAL POLICY

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

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 we will file insurance claims with an assignment of benefits, with the exception of Medi-Share and other medical expense sharing plans. If necessary a claim form will be provided for any unfiled claims. We participate with most major insurance companies. Please contact your insurance company directly if you have any questions regarding participation.

Please remember the following regarding insurance:

- 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 for any medical condition, regardless of coverage.

High Deductible Health Plan (HDHP):
If you have a HDHP (i.e. you do **not** have a copay when you visit your physician office) and your deductible is **unmet**, you will be asked to pay $50 at the time of check-in. The $50 will be applied toward the total cost of your care for the day and Urology, P.C. will bill you for the remaining balance. If you are uncertain if you have a HDHP, please be prepared to pay $50 at the time of check-in.

No Insurance Coverage/Self Pay:
If you have no insurance coverage or insurance information is not provided at check-in, you will be asked to pay $50 at the time of check-in. The $50 will be applied toward the total cost of your care for the day, and Urology, P.C. will bill you for the remaining balance.

Copays will be collected at the time of check-in.

There will be a $25 fee for any no show clinic appointments and a $50 fee for any surgery center procedure. This must be paid prior to rescheduling.

We accept cash, check, MasterCard, Visa, Discover and American Express. There will be a $25 charge on all returned checks.

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. We offer monthly auto debit payment plans based on account balance and low interest bank loans upon request. We do use outside agencies as a means of collections should we deem it necessary.

Please remember to bring your current insurance card and any referrals required by your insurance.

At your request, we can provide you an estimate of your financial obligations regarding any proposed treatment/surgery.

(OVER ➔)

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

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

Primary Care Physician: Address:

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	**Land Line:** ( ) ☐ 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

(OVER ➔)

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**

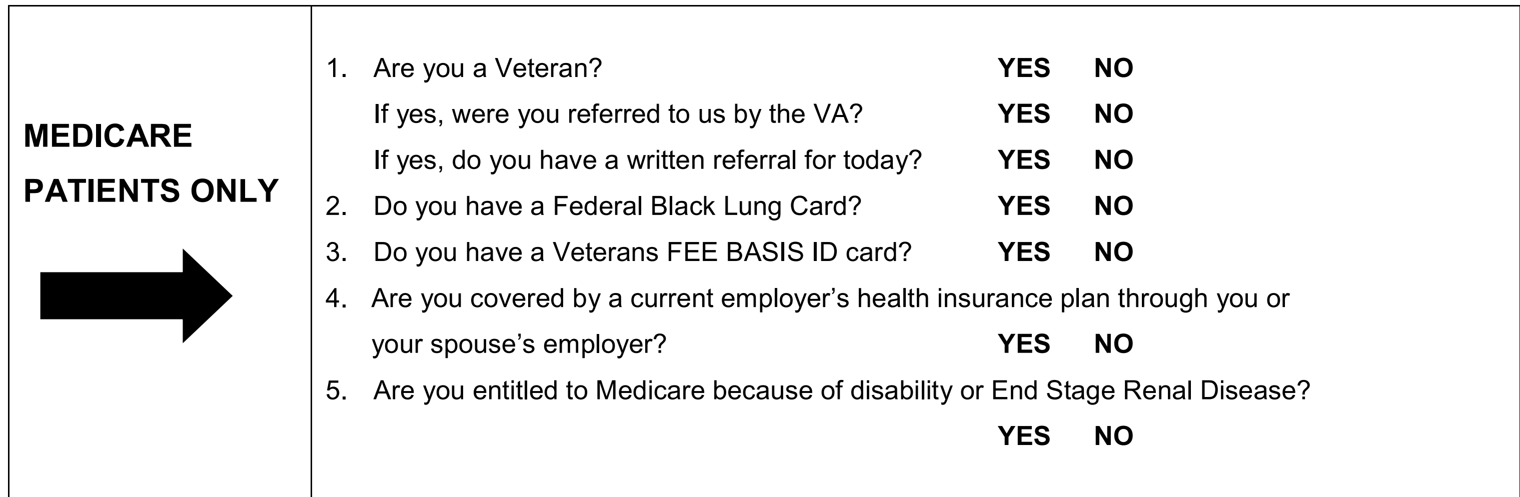
If yes, was it (choose one): **Work Related** **Auto** **Home** **Other**

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

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.** We offer monthly auto debit payment plans based on account balance and low interest bank loans upon request. We do use outside agencies as a means of collections should we deem it necessary.

→ 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 the Patient Rights and Responsibilities are listed on Urology, P.C.'s website at www.lincolnurologypc.com and I may request a copy at any time.

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

Signature____ Date ____________________

(OVER →)

Urology PC Health History

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

REASON FOR VISIT:	Preferred Pharmacy Name & Address:

Please circle YES or NO for each of the following:

Have you had a flu shot? NO YES When? _________
Pneumonia Vaccination? NO YES When?_________

List all **CURRENT MEDICATIONS** and dose including over-the-counter, aspirin meds, fish oil, inhalers and vitamins.

List all **ALLERGIES** to medications and your reactions. ☐ **None**

Allergy to Latex? NO YES

Have you had a reaction to or do you have an allergy to Iodine? NO YES

Allergy	Reaction	Allergy	Reaction
	☐ Unknown		☐ Unknown
	☐ Unknown		☐ Unknown
	☐ Unknown		☐ Unknown
	☐ Unknown		☐ Unknown
	☐ Unknown		☐ Unknown

Please List all **PREVIOUS SURGERIES** and year performed. ☐ **None**

Surgery	Year	Surgery	Year

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

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

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

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

(OVER ➔)

Personal Past Medical History: (please circle appropriate answer)

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

Anemia: NO YES	**Arthritis:** NO YES	**Asthma:** NO YES
COPD/Emphysema/ Chronic Bronchitis: NO YES	**Diabetes:** NO YES If yes, do you take medication for this? NO YES	**Heart Disease (bypass/ stent, surgery):** NO YES
Heart Rhythm Problems: NO YES	**Hepatitis / Liver Disease:** NO YES	**High Blood Pressure:** NO YES
History of Seizure: NO YES	**History of Stroke or TIA:** NO YES	**HIV:** NO YES
Kidney Disease: NO YES	**Multiple Sclerosis:** NO YES	**Muscular Dystrophy:** NO YES
Osteoporosis: NO YES	**Pacemaker/Defibrillator:** NO YES	**Parkinson's:** NO YES
Systemic Lupus: NO YES	**Thyroid Problems:** NO YES	**Urinary or Kidney Stones:** NO YES

Family Cancer History: (Please indicate type and family member) ☐ **None**

	Cancer	Cancer	Cancer	Cancer
What family member?				
What type?				

☐ I was adopted and have no available health history.

Total or Partial Joint Replacement NO YES

If yes, What joint? ___________________ When was surgery?________________________

If yes, have you been told to take antibiotics prior to surgery or dental procedures? NO YES

Anyone in your family have issues with anesthesia: 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: __________________

UROLOGY, P.C. & UROLOGY SURGICAL CENTER
5500 Pine Lake Road ·Lincoln, NE 68516

Name: ______________________________
Date of Birth: ______________________________
Date: ______________________________

MARITAL HISTORY

1. Patient's Age __________ Previous Marriage __________ Any Children __________
2. Wife's Age __________ Previous Marriage __________ Any Children __________
3. Year's Married __________ Duration of Infertility __________
4. Contraceptive Measures ______________________________
5. Coital Lubricants ______________________________
6. Premature Ejaculation ______________________________
7. Frequency of Intercourse ______________________________
8. Wife's Evaluation: __________ Physician: ______________________________
   Any Abnormalities: ______________________________
   ____

PERSONAL HISTORY

- ☐ Undescended Testes
- ☐ Veneral Disease
- ☐ Urinary Tract Infection
- ☐ Testicular Swelling/Trauma
- ☐ Irradiation, Chemicals
- ☐ Tight Shorts
- ☐ Allergies ____________________
- ☐ Mumps
- ☐ Prostatitis
- ☐ Epididymitis
- ☐ Diabetes
- ☐ Sauna or Tub Bath
- ☐ Fever 101° in Past 3 Months
- ☐ Blood Transfusion

SOCIAL HISTORY

Occupation ______________________________
Alcohol ______________________________ Quantity ______________________________
Smoking: Tobacco ______________________________ Marijuana ______________________________
Recreational Drug Use ______________________________ Type ______________________________

FAMILY HISTORY

Family History of Cystic Fibrosis Yes ________ No ________

PRIOR EVALUATION

Semen Analysis Yes _____ No ______, if yes, please have results faxed to 402-421-1945

PRIOR INFERTILITY THERAPY

____