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.

You are scheduled for an appointment regarding erectile dysfunction 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 $50 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

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

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

Allergy to Latex? NO YES

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

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: _____

(OVER ➔)

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

International Index of Erectile Function (IIEF) Questionnaire

(Write the number that best describes your erectile function for the past 4 weeks in the spaces provided.)

Over the past four weeks:

1. How often were you able to get an erection during sexual activity? _____

0 = No sexual activity
1 = Almost never/never
2 = A few times (much less than half the time)
3 = Sometimes (about half the time)
4 = Most times (much more than half the time)
5 = Almost always/always

2. When you had erections with sexual stimulation, how often were your erections hard enough for penetration? _____

0 = No sexual activity
1 = Almost never/never
2 = A few times (much less than half the time)
3 = Sometimes (about half the time)
4 = Most times (much more than half the time)
5 = Almost always/always

3. When you attempted sexual intercourse, how often were you able to penetrate (enter) your partner? _____

0 = Did not attempt intercourse
1 = Almost never/never
2 = A few times (much less than half the time)
3 = Sometimes (about half the time)
4 = Most times (much more than half the time)
5 = Almost always/always

4. During intercourse, how often were you able to maintain your erection after you had penetrated (entered) your partner? _____

0 = Did not attempt intercourse
1 = Almost never/never
2 = A few times (much less than half the time)
3 = Sometimes (about half the time)
4 = Most times (much more than half the time)
5 = Almost always/always

5. During sexual intercourse, how difficult was it to maintain your erection to completion of intercourse? _____

0 = Did not attempt intercourse
1 = Extremely difficult
2 = Very difficult
3 = Difficult
4 = Slightly difficult
5 = Not difficult

6. How many times have you attempted sexual intercourse? _____

0 = No attempts
1 = One to two attempts
2 = Three to four attempts
3 = Five to six attempts
4 = Seven to ten attempts
5 = Eleven or more attempts

7. When you attempted sexual intercourse, how often was it satisfactory for you? _____

0 = Did not attempt intercourse
1 = Almost never/never
2 = A few times (much less than half the time)
3 = Sometimes (about half the time)
4 = Most times (much more than half the time)
5 = Almost always/always

(OVER →)

8. How much have you enjoyed sexual intercourse? _____

0 = No intercourse
1 = No enjoyment
2 = Not very enjoyable
3 = Fairly enjoyable
4 = Highly enjoyable
5 = Very highly enjoyable

9. When you had sexual stimulation or intercourse, how often did you ejaculate? _____

0 = No sexual stimulation/intercourse
1 = Almost never/never
2 = A few times (much less than half the time)
3 = Sometimes (about half the time)
4 = Most times (much more than half the time)
5 = Almost always/always

10. When you had sexual stimulation or intercourse, how often did you have the feeling of orgasm or climax? _____

0 = No sexual stimulation/intercourse
1 = Almost never/never
2 = A few times (much less than half the time)
3 = Sometimes (about half the time)
4 = Most times (much more than half the time)
5 = Almost always/always

11. How often have you felt sexual desire? _____

1 = Almost never/never
2 = A few times (much less than half the time)
3 = Sometimes (about half the time)
4 = Most times (much more than half the time)
5 = Almost always/always

12. How would you rate your sexual desire? _____

1 = Very low/none at all
2 = Low
3 = Moderate
4 = High
5 = Very high

13. How satisfied have you been with your overall sex life? _____

1 = Very dissatisfied
2 = Moderately dissatisfied
3 = About equally satisfied and dissatisfied
4 = Moderately satisfied
5 = Very satisfied

14. How satisfied have you been with your sexual relationship with your partner? _____

1 = Very dissatisfied
2 = Moderately dissatisfied
3 = About equally satisfied and dissatisfied
4 = Moderately satisfied
5 = Very satisfied

15. How would you rate your confidence that you could get and keep an erection? _____

1 = Very low
2 = Low
3 = Moderate
4 = High
5 = Very High

Signature: _____

(OVER →)