Urology Tyler, PA

THOMAS C. BRIGHT, III, M.D.
Diplomate, American Board of Urology

STANTON P. CHAMPION, M.D.
Diplomate, American Board of Urology

J. LEONARD DECARLO, M.D.
Diplomate, American Board of Urology

CHARLES T. DICKSON, JR., M.D.
Diplomate, American Board of Urology

JAMES D. MCANDREW, M.D.
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R. CLAY WILLIAMS, D.O.
Diplomate, American Board of Urology

KEVIN J. MCQUAID, M.D.
Diplomate, American Board of Pathology

NEAL BURGESS, PA-C

700 Olympic Plaza Circle
Suite 700
Tyler, Texas 75701
(903) 262-3900
(903) 262-3993 Fax

PROSTATE CANCER CENTER

JOHN M. BARNETT, M.D.
Diplomate, American Board of Radiology

911 South Beckham
Tyler, Texas 75701
(903) 262-3900
(903) 262-3992 Fax

www.urologytyler.com

Dear Patient,

Thank you for selecting Urology Tyler, PA for your urological care. We have built a practice founded on concern for the patient that is supported by a caring, professional staff.

In order to serve you better, we have enclosed our Patient Information forms. **Please complete and sign these forms before your visit, and bring them with you.** The forms should be filled out with your name as it appears on your insurance cards.

Always bring all your insurance information (i.e. Medicare, Medicaid, Insurance cards) with you at your appointed time. You must bring a picture identification to each appointment.

Bring a list of all your medications and surgeries.

Please be prepared to give a urine sample at the time of your visit.

The entire staff of Urology Tyler, PA will strive to make your visit with us informative and as pleasant as possible. We truly appreciate the confidence you have placed in us. We look forward to meeting you and sharing in your care.

Sincerely,

Urology Tyler, PA

PATIENTS WITH MEDICARE

Of course, we accept Medicare patients. If you have chosen a plan other than standard Medicare, check with your insurance company prior to your visit to determine if our doctor is in the plan. If any referral is necessary, it is your responsibility to obtain it prior to the visit. You will also need to know what hospital, lab and pathology facility you are required to use. **This is also necessary for Medicare supplements**.

PATIENTS WITH PPO INSURANCE

If your insurance is a "PPO", please check with your insurance company to see if the doctor you will be seeing at Urology Tyler is in your network PRIOR TO YOUR APPOINTMENT. If we are not in network, you will be required to pay all charges at the time of your visit. You will also need to know what hospital, lab and pathology facility you are required to use.

PATIENTS WITH HMO INSURANCE

If your insurance company is an "HMO" and requires you to have a referral from your primary care physician (PCP), *please* call them and make sure they have sent it to us BEFORE your appointment. If we do not have the referral, you will be required to pay all charges at the time of your visit. You also need to know what hospital, lab and pathology facility you are required to use.

SELF-PAY PATIENTS WITHOUT MEDICARE OR INSURANCE

It is our understanding that you will be receiving services from Urology Tyler on a *self-pay basis*. The charge for the **first** visit with the doctor will be a minimum of $400. Please come prepared to pay for all charges from the first visit. Since we are a specialist, many times more tests or treatment is needed. At the time these services are provided, payment is due in full. If you have any questions, please discuss them with our staff.

ALL insurance patients must know what kind of insurance coverage you have. Check with your insurance carrier before you see us if you are not sure. All patients are required to pay their deductible, copay, or percentage amounts at the time of service.

PLEASE ALWAYS BRING YOUR INSURANCE CARD(S) WITH YOU TO EACH APPOINTMENT.

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Pre-Authorization Policy

As your physicians we always strive to give you the best treatment recommendations and prescribe the most suitable medications to treat your condition. Prescribing medication is a complex task, looking at the risk versus the benefit, and taking into consideration your overall health and other medications.

Recently we have been bombarded with requests for "Pre-Authorizations" of medications. Simply put, this is an attempt by your prescription insurance to not pay for the medication we prescribe. The "preauthorization" process is very time consuming for the doctors and nurses, and often results in the insurance company denying coverage.

Insurance companies keep limited formularies to save money. They also change their covered drug list, so what is covered one year may not be covered the next.

Effective Immediately, we will no longer be able to pre-authorize medications. So, where does that leave you? You have four choices:

1. Pay for the medication out of your own pocket (you may want to look into getting the medication out of Canada, as it may be cheaper. The down side is it may not be the same quality as medications you have come to expect from the USA.)
2. Change your prescription insurance coverage to a plan that will cover that medication.
3. Bring a copy of your formulary and we will see if there is an appropriate substitute for the drug we have prescribed.
4. For a $50.00 fee, we will try to get the authorization for you; however please keep in mind that the authorization may still be denied by your insurance company. This fee is due in advance and is nonrefundable.

Appointment No Show Policy

Also effective immediately, there will be a **$25.00** fee for any appointment that is not cancelled prior to your scheduled visit. This $25.00 must be ***paid in full before*** your next visit.

UROLOGY TYLER, PA   Today's Date: ____________

Patient Name: ____

Mailing Address: ______________________ City: ____________ State: ___ Zip: __________

Email Address: ____

Home Phone: ________________________ Cell Phone: ______________________

Employer: ____________________________ Work Phone Number: ______________

Sex: M F Date of Birth: ______________ Age: ______ Social Security #: ______________

Married ___________ Single ___________ Widowed ___________ Divorced ___________

Race: ____ American Indian or Alaska Native ____ Asian ____ Black/African American

____ Native Hawaiian/Other Pacific Islander ____ White ____ Other Race: ______________

Ethnicity: ____ Hispanic or Latino ____ Not Hispanic or Latino ____ Unknown

Preferred Language: ____ English ____ Other: ______________________________

****

1.) Name of Spouse (or parent if younger than 18): ______________________

Social Security #: ____________________ Date of Birth: ______________

Address (if different from patients): ______________________________

2.) Emergency Contact (person not living with you): ______________________

Address: ____________________ Relationship ____________ Phone: __________

****

Who is your Primary Care Physician (PCP) or Family Dr.? ______________________

List all of your current physicians: ______________________________________

****

PRIMARY INSURANCE ____

Address for claims and billing: ______________________________________

Name of Insured: ____________________ Date of Birth ____________ SS #: __________

Insured's Employer ____

Relationship to patient: ________________ Group #: ______________ ID # __________

SECONDARY INSURANCE ____

Address for claims and billing: ______________________________________

Name of Insured: ____________________ Date of Birth: ____________ SS # __________

Relationship to patient: ________________ Group #: ______________ ID #: __________

****

FOR OFFICE USE ONLY: Patient Account Number ____________________

Patient Medication Information

Today's Date: ______________________________

Patient Name: ______________________________

Date of Birth: ____________ Urology Tyler Doctor: ____________

Pharmacy Name: ____________________City: ________________

** Please fill out this form completely **with all doctor prescribed** medications**

Current Medication Name:	Mg (Dose):	How often do you take it:
Example: Levaquin	500 mg	1 per day

Usually, do you want your prescriptions: (Check One) ____ Sent immediately to the pharmacy
____ Printed on paper to take with you

Allergies: ______________________________

For Office Use Only:

Imputed into computer: ______

Initials:______________

Account #: ______________

Urology Tyler, P.A.

Name: ______________________ Date: ______________________

Medical History

Circle Y or N for every Question

High Blood Pressure	Y	N
Diabetes	Y	N
Stroke	Y	N
Kidney Stones	Y	N
Kidney Failure/Dialysis	Y	N
Heart Disease	Y	N
Incontinence	Y	N
Urinary Tract Infections	Y	N
Artif. Joint or Heart Valves	Y	N
Cancer (list type and date)	Y	N

Smoking	Y	N
How much (packs/day) ____________		
Drinking (alcohol)	Y	N
How much		
Other ______________________		

____

____

____

____

____

Surgical History

List any surgical procedures with approximate date

____

____

____

____

____

____

____

Systems Review

Circle Y or N for every Question

Fever	Y	N
Chills	Y	N
Headache	Y	N
Weight Loss	Y	N
Hay Fever	Y	N
Sinus Problems	Y	N
Bleeding Problems	Y	N
Tremors	Y	N
Seizures	Y	N
Chest Pain	Y	N
Wheezing	Y	N
Frequent Cough	Y	N
Shortness of Breath	Y	N
Blood in Sputum	Y	N
Excessive Thirst	Y	N
Abdominal Pain	Y	N
Nausea / Vomiting	Y	N
Indigestion / Heartburn	Y	N
Blood in Stool	Y	N
Skin Rash	Y	N
Glaucoma	Y	N

Family History

Circle Y or N for any blood relatives affected

Diabetes	Y	N
Bleeding Problems	Y	N
Heart Disease	Y	N
Kidney Stones	Y	N
Prostate Cancer	Y	N
Kidney Cancer	Y	N
Bladder Cancer	Y	N
Other Cancer (list) ______________		

PATIENT AUTHORIZATION AND ASSIGNMENT OF BENEFITS

ASSIGNMENT OF BENEFITS, ASSIGNMENT OF RIGHTS TO PURSUE ERISA AND OTHER LEGAL AND ADMINISTRATIVE CLAIMS ASSOCIATED WITH MY HEALTH INSURANCE AND/OR HEALTH BENEFIT PLAN (INCLUDING BREACH OF FIDUCIARY DUTY) AND DESIGNATION OF AUTHORIZED REPRESENTATIVE

ASSIGNMENT OF INSURANCE BENEFITS In consideration of services rendered, I hereby assign and transfer to **UROLOGY TYLER, P.A.**, referred to as "Association" for myself and my dependents all rights, title, and interest in the benefits payable for services rendered by the Association provided in any insurance policy(ies) under which I or any of my dependents are insured. Said irrevocable assignment and transfer shall be for the purpose of granting the Association an independent right of recovery in any policy(ies) of insurance, to which benefits may be payable for the medical services I receive for this Admission, but shall not be construed to be an obligation of the Association to pursue any such rights or recovery.

I hereby authorize and assign payment to and other Physician, Anesthetist, Radiologist, Lab, and any other independent practitioners for the medical services I receive for this Admission. Each person signing the Admission Agreement is financially responsible for charges not collected by this assignment to the Association within 30 days.

I also assign to the Association and other Physician, Anesthetist, Radiologist, Lab, and any other independent practitioners for the medical services I receive for this Admission all rights, title, and interest in benefits payable out of any third party action against any other person, entity, or insurance company, or out of recovery under the uninsured motorist provisions of the medical payment provisions of any automobile insurance policy(ies) or any other insurance policy(ies) under which I may be entitled to recover.

I also authorize my plan administrator, fiduciary, insurer, and/or attorney to release to the Association and other Physician, Anesthetist, Radiologist, Lab, and any other independent practitioners any and all Plan documents, summary plan description, insurance policy, and/or settlement information upon written request from the Association and any other Physician, Anesthetist, Radiologist, Lab, and independent practitioners or its attorneys in order to claim such medical benefits for the medical services I receive for this Admission.

I also assign and/or convey to the Association and any other Physician, Anesthetist, Radiologist, Lab, and independent practitioners any legal or administrative claim arising under any group health plan, employee benefits plan, individual health insurance plan concerning medical expenses incurred as a result of the services I receive for this Admission (including any right to pursue those legal or administrative claims.) This constitutes an express and knowing assignment of ERISA breach of fiduciary claims and other legal and/or administrative claims.

The Association and any other Physician, Anesthetist, Radiologist, Lab, and independent practitioners as my assigned and designated authorized representative may bring suit against any such health care benefit plan, employee benefit plan, plan administrator or insurance company in my name with derivative standing at their expense. Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA, ERISA, Medicare, and applicable federal and state laws.

I understand that regardless of my assigned insurance benefits, I am responsible for the total charges for all services rendered. I agree to pay Urology Tyler, PA any and all charges not paid for by insurance. Copayments or deductibles are due, in full, at the time of service.

I grant permission for Urology Tyler, PA to render such care that my physician may deem necessary in my diagnoses and treatment. I understand that such care may include medical and surgical treatment, laboratory tests, and diagnostic tests, such as cystoscopy.

I certify that the information given in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to Urology Tyler, PA and authorize Urology Tyler, PA to submit claims to Medicare for payment. I understand that I am responsible for any health insurance deductibles and coninsurance.

I hereby authorize Urology Tyler, PA to disclose necessary information from the patient's medical record to the following parties when requested for the purposes as stated herein; to any physician for the purpose of providing continuing professional care and to any insurance company or third party payor for the purpose of obtaining payment to Urology Tyler, PA for the services provided. Urology Tyler, PA, its employees, officers and physicians are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein. I understand this release specifically includes any and all blood related tests including test results reflecting presence of HIV, HBV, and the diseases, all of which I specifically authorize to be so released.

I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT.

______________________________ ______________
Patient Signature Date

____
Patient Name (Printed)

I approve the following person and/or family members to receive medical information and copies of my medical records.

____

____

______________________ ______________ ______________
Signature of Representative Relationship Date

____
Printed Name of Representative

Acknowledgment of Review of Notice of Privacy practices

I have had the opportunity to read this office's complete Notice of Privacy Practices which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

I understand that by signing this form I consent to the following:

1) Sharing information for purpose of treatment: You will share my information with all members of my treatment team, both within this office and with other providers (personal and institutional) in order to provide me with quality care.

2) Sharing of information for purpose of payment: You will share all necessary information with my insurer(s), payor(s), governmental entitles (such as Medicare, Medicaid, etc.) and their representatives (including, but not limited to, benefit determination and utilization review) as well as your representatives involved in the billing process (including, but not limited to) claims representatives, data warehouses, billing companies.

3) Sharing of information for purposes of operations: You will share all information necessary for ongoing operations of this office including, (but not limited to) the credentialing processes, peer review, accreditation and compliance with all federal and state laws.

______________________________	______________________________
Patient's Name (Printed)	Date
______________________________	______________________________
Patient's Signature (or guardian, if a minor)	Relationship (if a minor)

FOR MORE DETAILED INFORMATION, THERE IS A COMPLETE COPY OF THE NOTICE OF PRIVACY PRACTICES IN OUR WAITING ROOM OR YOU CAN ASK THE RECEPTIONIST FOR A COPY.

Attachment "A"

Urology Tyler
Notice of Protected Health Information Practices

<u>This notice describes how medical information about you may be used and disclosed and</u>

Understanding Your Health Record/ Information

This notice describes the practices of Urology Tyler and that of its physicians with respect to your protected health information created while you are a patient at Urology Tyler. Physicians and personnel of Urology Tyler authorized to have access to your medical chart are subject to this notice. In addition, physicians of Urology Tyler may share medical information with each other for treatment, payment or health care operations described in this notice.

We create a record of the care and services you receive at Urology Tyler. We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. This notice applies to all of the records of your care at Urology Tyler.

This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

Your Health Information Rights

Although your health record is the physical property of Urology Tyler, the information belongs to you. You have the right to:

• Request a restriction on certain uses and disclosures of your information for treatment, payment, health care operations and as to disclosures permitted to persons, including family members involved with your care and as provided by law. However, we are not required by law to agree to a requested restriction;

• Obtain a paper copy of this notice of protected health information practices;

• Inspect and request a copy of your health record as provided by law;

• Request that we amend your health record as provided by law. We will notify you if we are unable to grant your request to amend your health record.

• Obtain an accounting of disclosures of your health information as provided by law;

• Request communication of your health information by alternative means or at alternative locations. We will accommodate reasonable requests; and

• Revoke your authorization to use or disclose health information except to the extent that action has already been taken in reliance on your authorization.

You may exercise your rights set forth in this notice by providing a written request, except for requests to obtain a paper copy of the notice to Urology Tyler at 700 Olympic Plaza, Ste. 700, Tyler, Texas 75701.

Our Responsibilities

In addition to the responsibilities set forth above, we are also required to:

• Maintain the privacy of your health information;

• Provide you with a notice as to our legal duties and privacy practices with respect to information we maintain about you;

• Abide by the terms of this notice;

• Notify you if we are unable to agree to a requested restriction on certain uses and disclosures;

• We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain, including information created or received before the change. Should our information created or received before the change. Should our information practices change we are not required to notify you, but we will have the revised notice available for you to request at any Urology Tyler location. The revised notice will also be posted at our offices and on the Urology Tyler web page at <u>www.urologytyler.com</u> and

• We will not use or disclose your health information without your written authorization, except as described in this notice.

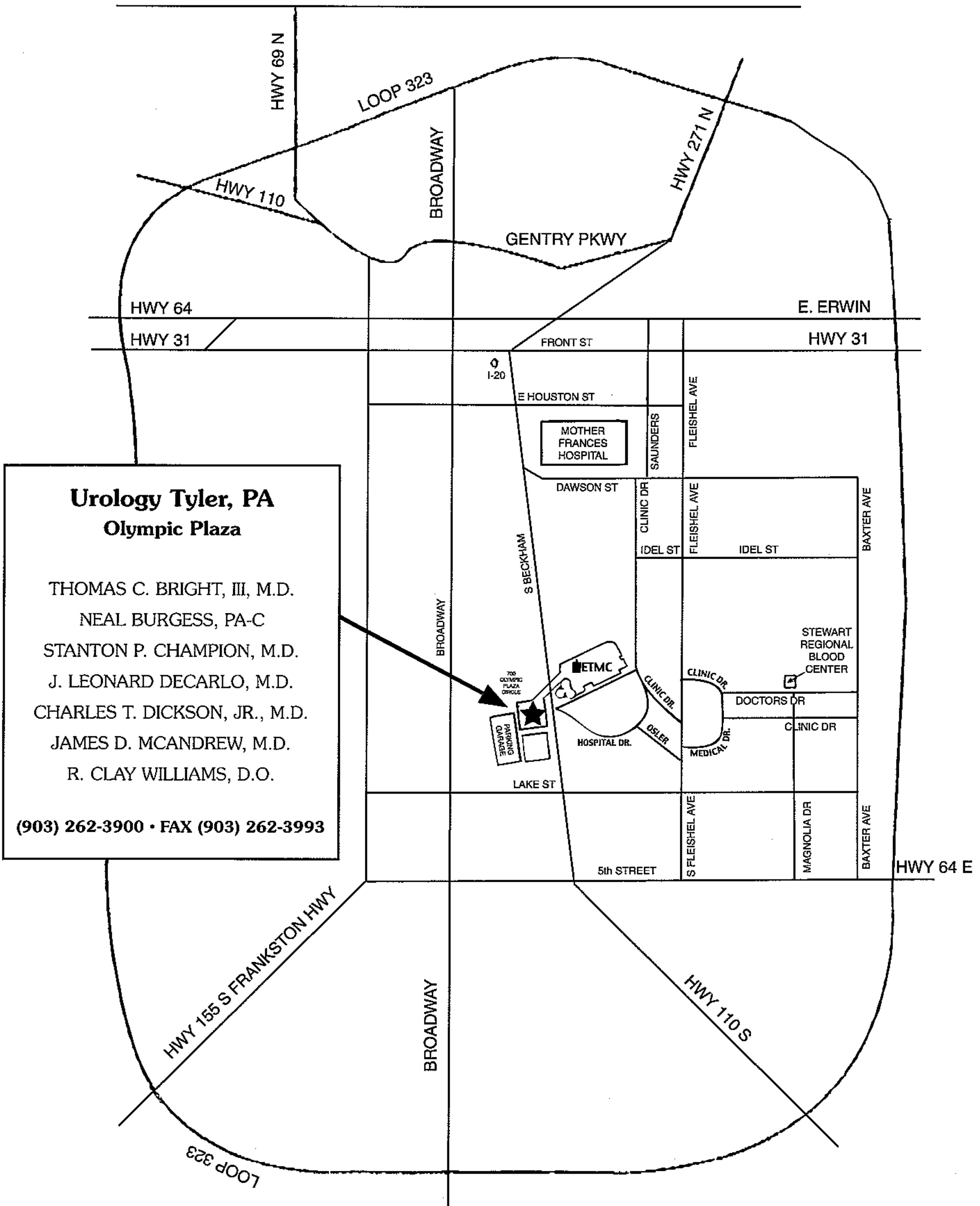
Examples of Disclosures for Treatment, Payment, Health Care Operations and As Otherwise Allowed By Law.

The following categories describe

Urology Tyler, PA

700 Olympic Plaza Circle
Suite 700
Tyler, Texas 75701

N



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