NORTH DALLAS UROLOGY ASSOCIATES

5300 W. Plano Parkway, Suite 200
Plano, Texas 75093
972-612-8037 ♦ 972-543-1984 (fax)

4501 Medical Center Drive, Suite 100
McKinney, Texas 75069
972-548-8195 ♦ 972-548-8866 (fax)

Date:_____

First Name:_____ **Last Name:**_____ **MI:**____

Address:_____ **Apt/Suite:**_____

City:_____**State:**_____**Zip:**_____

Cell Phone:_____ **Work Phone:** _____ **Home Phone:** _____

Social Security #:_____ **Date of Birth:** _____

Patient Marital Status: S / M / D / W **Patient Sex: Male / Female** **Employed: Yes / No / Ret / Dis**

Occupation: _____ **Employer:**_____

For Reporting Purposes only:
Primary Language Spoken:_____ **Ethnicity:**_____ **Race:**_____

E-Mail: _____

Appointment Reminder Preference: **Phone** (Voice Recording) **Text** **E-mail**

INSURANCE INFORMATION:
Primary Insurance:_____
Name of Policy Owner:_____ **DOB:**_____ **Relation:**_____
Secondary Insurance: _____
Name of Policy Owner:_____ **DOB:**_____ **Relation:**_____

Do you reside in an ASSISTED LIVING or a NURSING FACILITY? Yes / No
If yes, please fill out the following information:

Name of Facility:_____
Address:_____ **Phone:**_____

HAVE YOU EVER SEEN ONE OF OUR DOCTORS BEFORE?: YES / NO, If Yes, whom:_____
In case of emergency notify:_____ **Phone:**_____ **Relation:**_____

Primary Care Physician:_____ **Referred by:**_____

How did you hear about us:_____

NORTH DALLAS UROLOGY ASSOCIATES

5300 W. Plano Parkway, Suite 200
Plano, Texas 75093
972-612-8037 ♦ 972-543-1984 (fax)

4501 Medical Center Drive, Suite 100
McKinney, Texas 75093
972-548-8195 ♦ 972-548-8866 (fax)

FINANCIAL RESPONSIBILITY AGREEMENT

I, _____, understand that I am responsible for all charges incurred for my medical treatment. I consent that medical benefits from my insurance policy are paid directly to North Dallas Urology Associates, in consideration of services rendered up to the total amount of my account.

Any balance remaining after insurance benefits have been paid is my responsibility. I will pay the balance within 60 days unless other arrangements have been made. I understand that in the event of default, my account will be sent to a collection agency.

It is my responsibility to provide the correct insurance information (claims address, phone numbers, ID numbers, etc.). I will pay any balances resulting from inaccurate insurance information.

NORTH DALLAS UROLOGY will file claims with my primary and secondary insurance companies ONLY. If I have a third insurance company, I will file those claims myself. I understand that I am responsible for all remaining balances after my second insurance company has paid.

Every possible effort will be made to obtain payment for my claims. I agree to pay my account balance in the event the insurance company (ies) does not respond.

ALL COPAYS AND DEDUCTIBLES ARE DUE AT TIME OF SERVICE. I also agree to pay for in-office labs/x-rays/tests at the time of service as outlined by my insurance company.

There is a $45.00 fee for disability forms that need to be completed prior to surgery or any form requiring dictation by the doctor, and a $25.00 fee for a copy of your medical records.

It is my responsibility to obtain all referrals and to verify the in-network status of my doctor. If I do not have a proper referral, my appointment will be rescheduled until one is obtained.

I authorize the release of medical records necessary to process insurance claims.

Signature:_____ Date:_____

NORTH DALLAS UROLOGY ASSOCIATES

5300 W. Plano Parkway, Suite 200
Plano, Texas 75093
972-612-8037 ♦ 972-543-1984 (fax)

4501 Medical Center Drive, Suite 100
McKinney, Texas 75069
972-548-8195 ♦ 972-548-8866 (fax)

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- **Conduct, plan, and direct my treatment and follow-up care among the multiple healthcare providers who may be involved in that treatment directly and indirectly.**
- **Obtain payment from third party payors.**
- **Conduct normal healthcare operations such as quality assessments and physician certifications.**

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of *Notice of Privacy Practices*.
I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

Patient Name:_____**Date:**_____

Signature of patient (or Authorized Representative):_____

Relationship to Patient:_____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement of this *Notice of Privacy Practices Acknowledgement,* but was unable to do so as documented below:

DATE:_____ **INITIALS:**_____ **REASON:**_____

Signature:_____

Physician Disclosure

To further our commitment to the quality of medical and surgical care for our patients, we have chosen to be an owner in the entities listed below.

Our ownership enhances our ability to direct the manner in which your care is delivered at the facility. If this of concern to you, the Physicians' will be happy to answer any questions.

We are on the medical staff at other healthcare facilities and will be happy to discuss your option of choosing an alternative location.

Surgery Center of Plano
Upright & Open Imaging
McKinney Surgery Center
Baylor Medical Center at Frisco
North Dallas Radiation Oncology Center
Methodist McKinney Hospital
US Lithotripsy

ACKNOWLEDGEMENT: (I / We) have read this "Notice to Patients" form, and (I / We) understand the disclosures that it contains.

Date this _____ Day of _____, 20___

_____
Signature of Patient or Guardian

North Dallas Urology Associates
5300 W. Plano Parkway, Suite 200
Plano, Texas 75093
972-612-8037 ♦ 972-543-1984 (fax)

North Dallas Urology Associates
4501 Medical Center Drive, Suite 100
McKinney, Texas 75069
972-548-8195 ♦ 972-548-8866 (fax)

NORTH DALLAS UROLOGY ASSOCIATES

5300 W. Plano Parkway, Suite 200
Plano, Texas 75093
972-612-8037 ♦ 972-543-1984 (fax)

4501 Medical Center Drive, Suite 100
McKinney, Texas 75069
972-548-8195 ♦ 972-548-8866 (fax)

PATIENT AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Date:_____

Patient Name:_____

Date Of Birth:_____

Description of the specific information to be used or disclosed: (Please check one of the following:)

☐ **All information**

Or Specific information like the following (Please list below)

☐ **pick up patient's medical records**
☐ **cancel, reschedule, make appointments for patient**
☐ **call to get patient's results**
☐ **pick up patient's medicine/samples**

Write names of people we can give out information to and the relationship to them. If you *DO NOT* want us to release any information to anybody, just cross out the page.

Name:_____ **Relationship:**_____ **phone:**_____
Name:_____ **Relationship:**_____ **phone:**_____
Name:_____ **Relationship:**_____ **phone:**_____
Name:_____ **Relationship:**_____ **phone:**_____
Name:_____ **Relationship:**_____ **phone:**_____

I understand that:

- **I may inspect or copy the protected health information to be used or disclosed.**
- **I may revoke this authorization in writing by contacting your office at the address above, attention Privacy Officer.**
- **Information used or disclosed pursuant to the Authorization may be subject to re disclosure by the recipient and no longer be protected by HIPAA.**

Patient Signature:_____ **Date:**_____

NORTH DALLAS UROLOGY ASSOCIATES

5300 W. Plano Parkway, Suite 200
Plano, Texas 75093
972-612-8037 ♦ 972-543-1984 (fax)

4501 Medical Center Drive, Suite 100
McKinney, Texas 75069
972-548-8195 ♦ 972-548-8866 (fax)

NAME:_____ **DATE:**_____

Preferred Laboratory for blood work:_____

Pharmacy Name:_____ **Location:**_____ **Phone:**_____

LIST OF SURGERIES/ PAST MEDICAL HISTORY

1._____
2._____
3._____
4._____
5._____

PRESCRIPTIONS or OVER THE COUNTER:	**MG (dosage)**	**TIMES A DAY?**	**# Per Day**

ALLERGIES TO MEDICATION:

1._____ **3.**_____
2._____ **4.**_____

Have you ever smoked or used tobacco products? YES NO
_____Current Smoker (how many cigarettes per day do you smoke?) _____
Are you interested on quitting? YES NO
_____Former Smoker (when was last date you smoked?) _____

Do you drink alcohol now or in the past? YES NO
How often have you had 6 or more drinks on one occasion in the past year? (circle one)
Never Daily Weekly Monthy

Are you allergic to iodine or dye contrast? YES NO

Do you have prostate cancer in your family? YES NO

FAMILY HISTORY OF MEDICAL ILLNESS:

Father :_____ **Paternal grandfather:**_____
Mother :_____ **Paternal grandmother:**_____
Maternal grandfather:_____ **Maternal grandmother:**_____

What symptoms are you having today?

NAME:_____ **DATE:**_____

- □ **Fever**
- □ **Chills**
- □ **Headaches**
- □ **Blurred Vision**
- □ **Pain**
- □ **Sore Throat**
- □ **Sinus Pain**
- □ **Mouth Ulcers**
- □ **Runny Nose**
- □ **Tremor**
- □ **Dizziness**
- □ **Tingling/numbness**
- □ **Too Hot/Cold**
- □ **Tired/Sluggish**
- □ **Loss of Libido**
- □ **Rash**
- □ **Itching**
- □ **Boils**
- □ **Abdominal Pain**
- □ **Nausea**
- □ **Vomiting**
- □ **Diarrhea**
- □ **Constipation**
- □ **Chest Pain**
- □ **Varicose Veins**
- □ **High Blood Pressure**
- □ **Swelling of ankles**
- □ **Joint Pain**
- □ **Neck Pain**
- □ **Back Pain**
- □ **Urinary Incontinence**
- □ **Pain with Urination**
- □ **Urinary Urgency**
- □ **Urinary Frequency**
- □ **Urinary Retention**
- □ **Pain with Intercourse**
- □ **Erectile Dysfunction**
- □ **Wheezing**
- □ **Shortness of Breath**
- □ **Seasonal Allergies**
- □ **Swollen Glands**
- □ **Blood Clotting Problem**
- □ **Anxiety**
- □ **Depression**

NORTH DALLAS UROLOGY ASSOCIATES

PAYMENT POLICY

Upon contact with our business office, we will request your insurance information. We are required by many insurance companies to get pre-certification numbers and benefits. This protects you as well as us from having unexpected out-of-pocket expenses. Our staff will call your insurance company to verify your benefits and also check on your current deductible, co-payment, and coinsurance. This information will be shared with you. In order to control our billing costs, we request deductible, co-payment, and/or coinsurance be paid as they relate to the charges at the time of service. Payment may be made by cash, check, Master Card, Visa, Discover, or American Express.

MEDICARE PATIENTS

If your primary insurance is Medicare, then we will file the claim for you. We do accept Medicare assignment which means we will bill you only what Medicare allows. Medicare will pay 80% of the allowable, minus any deductibles, and you will be responsible for the 20% allowable plus any remaining deductible. If you have a secondary insurance policy, we will file that for you as a courtesy. Some secondary insurance policies reimburse directly to the patient and/or insured. If your insurance company does this, please forward the payment to us in the form of cash, check or credit card.
Note: At times, there may be a procedure or test done in-office that is required to be sent out to a lab or pathologist. In this case you may be billed by a third party for these services.

LABS

We, out of courtesy collect your specimen and send it to our preferred lab for processing and analyzing of results. We do not have the capability to provide this service in our office, therefore if you do not wish to have your specimen collected or sent to our preferred laboratory please specify prior to services. We use the following laboratories Clear Point, Bostwick & Dr. Donna Sirbasku Pathologist.

MANAGED CARE PATIENTS

We request you pay your co-payment at the initial onset of your visit. If your deductible has not been met for the year, you will also need to pay any unmet deductible for the services rendered. After your deductible has been met, you will then be responsible for only your co-payment and/or coinsurance. Any procedure done may be subject to an additional surgical deductible depending on your particular insurance plan. We will file all claims for the services rendered by the physician. Assignment of insurance benefits, deductible, co-payments, and/or coinsurance are required before elective surgery. We will try to fulfill all insurance requirements for pre-certification; however, we cannot be responsible for reduction in benefits if this is not done. Therefore, we encourage you to contact your insurance company before any surgical procedures are done.
Note: At times, there may be a procedure or test done in-office that is required to be sent out to a lab or pathologist. In this case you may be billed by a third party for these services.

Please be advised that we request 24-hour cancellation notice prior to your scheduled appointment.

ASSIGNMENT OF BENEFITS

I authorize release of medical records to determine liability for payment and to obtain reimbursement. I assign all medical and/or surgical benefits including Medicare, private insurance, and other health plans to my physician. This assignment will remain in effect until revoked by me in writing. I understand I am financially responsible for all charges incurred by myself and/or dependent.

Signature:_____ Date:_____

Parent or guardian of minor:_____