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Full Name _____ **Maiden Name** _____

Address _____ **City** _____ **State** _____ **Zip** _____

1st name you go by _____ **Social Security#** _____ **Sex Male/Female**

Date of Birth _____ **Marital Status S / M / D / W**

Hm Phone _____ **Wk Ph** _____ **x** _____ **Cell Ph** _____

How did you learn about us? Referring Physician Yellow Pages Friend/Relative Lecture Other__

Referring Physician's Name _____ **Phone** _____

Employer _____ **Occupation** _____

Employer Address _____ **City** _____ **State** _____ **Zip** _____

Spouse or Legal Guardian/Parent

Full Name _____ **Relationship** _____ **Date of Birth** _____ **Phone** _____

Address _____ **City** _____ **State** _____ **Zip** _____

Social Security Number _____ **Employer** _____ **Work Phone** _____

Emergency Contact (friend/relative NOT living at your address)

Full Name _____ **Relationship** _____

Hm Phone _____ **Wk Ph** _____ **x** _____ **Cell Ph** _____

Primary Care Physician (if different from Referring Physician listed above)

Name _____

City where Practice is located _____ **Phone** _____

Please have your insurance card(s) available at check-in. All HMO's and some group plans require prior authorization for each office visit or service. You are responsible to see that you have the proper authorization. Please remember, if we do not receive the authorization you are responsible for all fees, regardless of insurance coverage. Thank you.

MALE PATIENTS – SKIP TO NEXT SECTION BELOW:

Day of last menstrual period: _____

Are you in menopause? ___yes ___no

Number of pregnancies? _____

How many deliveries? _____ Were they vaginal or cesarean section? _____

Date of last PAP _____ Date of last Mammography _____

Past Surgeries: Please check if appropriate and list approximate year.

- Cancer Surgery (type _____), Yr _____
- Heart Surgery (type _____), Yr _____
- Transplant Surgery (type _____), Yr _____
- Artificial Heart Valve, Yr _____
- Pacemaker, Yr _____
- Knee Replacement, Yr _____
- Hip Replacement, Yr _____
- Hernia Repair, Yr _____
- Back Surgery, Yr _____
- Neck Surgery, Yr _____
- Appendectomy, Yr _____
- Gall Bladder, Yr _____
- Tubal Ligation, Yr _____
- Vasectomy, Yr _____
- Hysterectomy, Yr _____
- Kidney removal, Yr _____
- Bladder Repair, Yr _____
- Prostate Surgery (type _____), Yr _____
- Stone Removal, Yr _____
- Ureteral Stents, Yr _____
- Colon Surgery, Yr _____
- Cystoscopy, Yr _____
- Other _____, Yr _____

Family History: Place check if Parents, Grandparents, Brothers or Sisters have had the condition.

- Cancer (type _____)
- High Blood Pressure
- Heart Disease
- Diabetes
- Stroke
- Kidney Stones
- Prostate Cancer
- Other _____

Social History:

Marital Status: married, single, divorced, widowed How many children do you have? _____

Occupation (current or former): _____

Do you smoke? ___yes ___no.

If yes, how many packs per day? _____ How long have you smoked? _____ years

Have you smoked previously? ___yes ___no If yes, when did you quit?

Do you drink coffee or tea? ___yes ___no Number of cups per day _____

Do you drink cola drinks? ___yes ___no Number consumed per day _____

Do you use artificial sweetener? ___yes ___no

If one glass of wine or one can of beer equals one drink, how many drinks do you have per week? _____

Patient Signature _____

Date _____

Provider Signature _____

Date _____

Patient Name: _____

Primary Care or Family Physician: _____

Pharmacy Name and Location	

Medication Allergies and Reactions	

List your Current Medications and What Condition You Take The Medication For.	

Over-the-Counter medications taken regularly (including vitamins, herbs, aspirin)	

Patients: Please read and initial beside each policy or consent and then sign where indicated.

ASSIGNMENT OF BENEFITS & AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I request that payment of authorized benefits (Medicaid, Medicare, and/or insurance companies) be made either to me or on my behalf to Urology Associates of Central MO. for any services furnished to me by my provider. I authorize any holder of medical information about me to release it to the following when applicable to determine benefits for related services:

- Division of Family Services
- Centers for Medicare and Medicaid Services
- Insurers and/or agents of these companies
- Responsible person(s) listed
- Other healthcare providers assisting in my medical care

CONSENT TO TREATMENT

I hereby authorize Urology Associates of Central MO.and/or any physician or authorized persons employed by them to perform and/or initiate medical evaluation and treatment and authorize and/or order any related services on my behalf.

FINANCIAL AGREEMENT

Unless other arrangements have been made in advance by either you or your health coverage carrier, payment in full is due at the time of service. Acceptable methods of payment are cash, personal checks, VISA, MasterCard or Discover.

We have made prior arrangements with many health plans to accept an assignment of benefits. We will submit a claim to those plans for which we have an agreement and will only require you to pay the authorized co-payment at the time of service. After the claim has been considered we will bill you for any deductible and or coinsurance not previously paid. If you have insurance coverage with a plan that we do not have a prior agreement, we will prepare and send a claim for you on an unassigned basis. This means our charges for your care and treatment are due at the time of service and your insurer will send their reimbursement directly to you.

If you have questions or concerns regarding your coverage for procedures, screenings services, medications or particular conditions, you are responsible for obtaining this information prior to your appointment. You agree to pay in full for all services considered “non-covered” services per your insurance policy if you choose to have the service provided.

If your insurance company does not pay for the services provided or you do not have insurance, you agree to pay all charges of Urology Associates of Central MO. Each bill is due and payable upon presentation or mailing of a statement to you. Should the account become delinquent, you agree to pay all costs of collection, including interest applied by a collection agency and attorney fees. Any suit filed may be brought in the county where the services are rendered.

CANCELLATION POLICY

Urology Associates of Central Missouri’s Cancellation Policy states the practice will assess a \$50 fee to patients who

- Do not show up for their appointment, or
- Cancel their appointment without a 24 hour notice.

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT

I received or have waived my right to a copy of Urology Associates of Central Missouri’s Notice of Privacy Practices.

I understand and agree to the above.

Signature of Patient **Date**

(For Patients 17 yrs of age or younger, parent or Guardian MUST sign)

OFFICE USE ONLY: Patient was offered, but forfeited a copy of Urology Associates of Central Missouri’s Notice of Privacy Practices

Signature of UACM Personnel **Date**