SHENANDOAH UROLOGIC SPECIALISTS

CONFIDENTIAL INFORMATION Last Name, First Initial _____

PATIENT INFORMATION AND AGREEMENT

Please Complete ALL sections

Date: _____

Patient's Name: _____
Last First Middle

Sex (circle one): M F Date of Birth: _____ Social Security #:_____

Address: _____

_____

Mailing Address (if different):_____

_____

Home Phone: _____ Cell: _____

Work Phone: _____Ext:_____ Other:_____

EMPLOYER: _____

Employer's Address: _____

Marital Status (circle one): S M W D

Spouse's Name: _____

Spouse's Date of Birth: _____ Spouse's Social Security #:_____

Spouse's Sex (circle one): M F

Name of emergency contact: _____

Phone:_____ Relation: _____

Name of nearest relative NOT living with you: _____

Phone: _____ Relation: _____

SHENANDOAH UROLOGIC SPECIALISTS

CONFIDENTIAL INFORMATION Last Name, First Initial _____

Reason(s) for visit:

_____

_____

Referring Doctor's Name:

_____

Primary Care Doctor's

Name:_____

LIST OF MEDICINES

Prescription Medicines

NAME	**STRENGTH**	**TIMES PER DAY**

Names of Non-prescription Medicines, Supplements, and Vitamins

_____

_____

_____

_____

_____

SHENANDOAH UROLOGIC SPECIALISTS

CONFIDENTIAL INFORMATION Last Name, First Initial _____

PLEASE READ AND SIGN BELOW

I authorize treatment of the patient named below and agree to pay all fees and charges for such treatment. I understand that any co-pays and/or any co-insurance payments are due at the time of service. I understand that if I have insurance and have provided accurate and complete information regarding my insurance, my SUS charges with the exception of co-pays or co-insurance payments will be filed with my insurance carrier; however, the responsibility for paying for services provided by SUS ultimately rests with the patient or responsible person. If I do not have insurance or my charges are not to be filed with insurance, payment in full for SUS services is due at the time of service. In the event legal action should become necessary to collect an unpaid balance due for medical services provided to me, I agree to pay all reasonable attorneys' fees (one-third of payments owed) and any other costs of collection including court costs. I hereby authorize assignment and payment directly to SUS for all services covered by the patient's major medical benefits.

_____

Patient's Signature Date

_____

Responsible Person's Signature (if different) Date

AUTHORIZATION BY PATIENT OR RESPONSIBLE PERSON. I certify that my insurance information is correct. I authorize Shenandoah Urologic Specialists (SUS) to apply for benefits on my behalf for the covered services they provide me. I request payments from my named insurance company to be paid directly to SUS for the treated person named below. I further authorize the release of any necessary information, including medical information for any related claim, to the insurance company.

IN ALL CASES, PROFESSIONAL FEES ARE THE RESPONSIBILITY OF THE PATIENT OR THE RESPONSIBLE PERSON. A finance charge will be assessed for the balance on any SUS bill that is NOT paid within 30 days of the billing date. This monthly finance change of 1-½ % (one and one-half percent) will be applied to the balance due, without deducting current payments and/or credits appearing on the bill, until the balance is paid in full. The patient or responsible party agrees to pay any and all finance charges as well as collection fees, court related costs, service and filing fees, interrogatory and garnishment fees, as well as any additional interest agreed to or that may be adjudicated for the collection of past due debts.

_____

Patient's Signature Date

_____

Responsible Person's Signature (if different) Date

SHENANDOAH UROLOGIC SPECIALISTS

CONFIDENTIAL INFORMATION Last Name, First Initial _____

Financial Policy

Thank you for choosing **Shenandoah Urologic Specialists** to serve your urologic needs. Please take the time to read the following, initial each section and sign/date the bottom of this form.

_____ Full payment is due at the time of service unless arrangements have been made prior to the start of any treatment.

_____ Insurance balances are ultimately the patient's obligation. We will file most primary insurances at no cost to you as a **COURTESY.** However, insurance balances which are not paid within 60 days may be billed to you. Please ask for a copy of all charge slips and follow up with your insurance to ensure prompt payment.

_____ Some of your treatment may **NOT** be covered by your insurance carrier. The cost for such charges will be your responsibility.

_____ Major services may require a deposit equal to at least one half of the estimated patient portion or payment in full at the time the appointment is made.

_____ Patients are asked to confirm their appointments at least 48 hours in advance by directly contacting our office or by responding to our confirmation contact. Failure to confirm your appointment may result in a charge for the time reserved, please see cancellation policy for specific charges.

_____ There will be a fee of $35.00 for any returned checks labeling Non-Sufficient Funds (NSF)

_____ Patient balances that go unpaid for 30 days or more may incure one or more of the following: **Interest charges of 1.5% per month or 18% APR collections (up to 42% of the full balance) and legal fees for collection of services.**

_____ _____

Signature of Patient or Guardian **Date**

_____ _____

Print Name **Witnessed By**

SHENANDOAH UROLOGIC SPECIALISTS

CONFIDENTIAL INFORMATION Last Name, First Initial _____

CANCELLATION & NO-SHOW POLICY

If you do not show up for your appointment AND if you had not cancelled your appointment at least 48 hours (two full days) in advance, SUS will charge you a “no-show fee”. The amount of the no-show fee will depend on the nature of your scheduled visit. For example, missed follow-up visits will result in a $50 no show fee and missed procedures and tests will result in a no-show fee of $100 or more. A no-show fee is a separate charge that will not be covered by your insurance plan.

BEFORE CHARGING YOU A NO-SHOW FEE, SUS MAY CONSIDER EXTENUATING CIRCUMSTANCE ON A CASE-BY-CASE BASIS.

You will need to pay the no-show fee in full before you schedule any future appointments.

WHY WE CHARGE A NO-SHOW FEE: A patient who does not show up for their appointment and who had not cancelled their appointment with at least 48-hours advance notice affects the care we provide our other patients and the cost of care. First of all, each no-show represents a missed opportunity for another SUS patient to see the doctor. Second, certain supplies and medications that we have ordered for you may be wasted if you do not show up. Every no show is inconsiderate and costs SUS time and money.

I understand the SUS no-show policy and agree to pay the SUS no-show fees above if I am a no-show and had not called the SUS office at least 48 hours in advance of my appointment to cancel.

Patient’s Name (PRINT) Patient’s Signature Date

_____ _____ _____

Responsible Person’s Name (PRINT) Responsible Person’s Signature Date

_____ _____ _____

Name of Responsible Person (if patient is under age 18) or (POA)

_____

Responsible person’s date of birth:_____ Social Security# :_____

Name and address of patient’s school:_____

_____

SHENANDOAH UROLOGIC SPECIALISTS

CONFIDENTIAL INFORMATION Last Name, First Initial _____

HIPAA STATEMENT

The ***Notice of Privacy Practices*** document has been made available and explained to me and my questions about the document have been answered.

I hereby authorize Shenandoah Urologic Specialists (SUS) to furnish my insurance company or other authorized agency my protected health information (PHI) for the purpose of treatment, payment or healthcare.

I also authorize SUS to discuss my medical condition and treatments with the following people:

Name (Please PRINT) Relationship (Spouse; Parent; Sibling; Child; or Friend)

_____

_____

_____

_____

_____

_____

_____

_____

Patient Authorization (Sign Below):

_____ _____ _____

Patient's Signature Responsible Person's Signature Date

PRIOR AUTHORIZATION FORMS

_____ Patients are responsible for obtaining their own prior authorization forms from their insurancy company. There will be a **$20.00** fee if the office has to get the necessary form which needs to be collected before the staff contacts the insurance company.