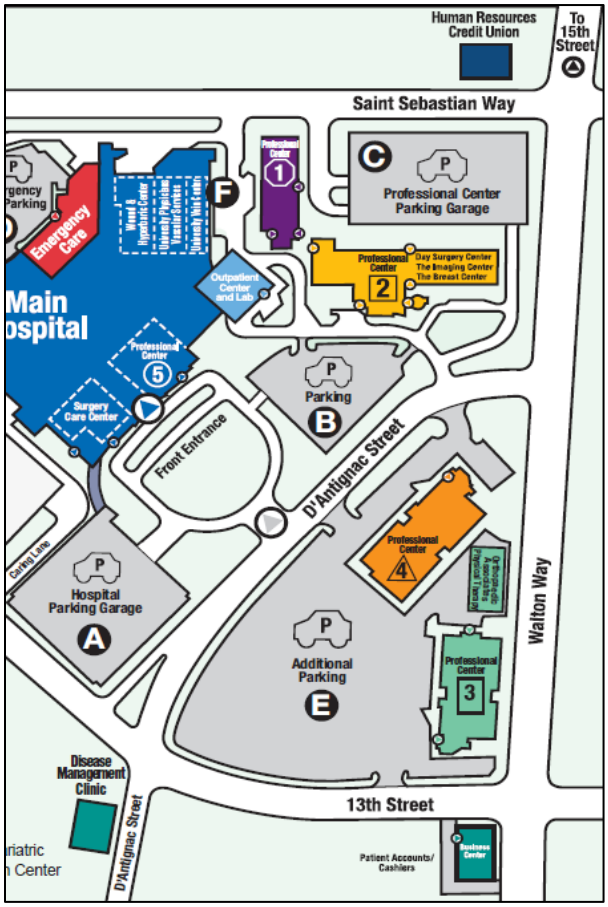
Augusta Urology Associates, L.L.C.

Your appointment is at:

☐ Evans Professional Center 4
4350 Towne Centre Drive, Suite 2200
Evans, GA 30809



☐ University Professional Building 2
818 St. Sebastian Way, Suite 403
Augusta, GA 30901

Please read and complete the following information in full. Bring this paperwork with you to your appointment, as well as your insurance card and a government issued photo ID.

Augusta Urology Associates, LLC/Augusta Urology Surgicenter, LLC Financial Policy

Insurance **Acct#: _____**

- We participate with most insurance plans, including Medicare. We do not participate with any Medicaid plans.
- If you are insured by a plan that we do not participate with, payment in full is required at each visit.
- Please provide the correct laboratory that your insurance participates with.
- Notification of insurance changes is your responsibility, as the patient. We require our staff to check your insurance card and driver's license at each visit. If you do not have your insurance card available at the time of your visit, you may pay for your visit in full or we will gladly reschedule your appointment. Failure to provide us with correct insurance information may result in your payment for charges regarding that visit.
- If you participate in a plan that requires prior approval from a primary care physician, please have your primary care physician provide us with the necessary approval prior to your visit.
- Contact your insurance company with any questions you may have regarding your coverage. It is your responsibility to confirm your benefits with your insurance company before seeing one of our physicians. In the event your health plan determines a service to be "not covered," you will be responsible for the charge(s).

Co-payments

- Any co-payments required by an insurance company must be paid at the time of service. If you do not have your co-payment at the time of your visit, we will be glad to reschedule your appointment.

Claims Submission

- We will submit your claim and assist you in any way we reasonably can to help get your claim paid.
- You must provide any information that your insurance company may request from you in a timely manner to expedite payment. If you fail to respond, you may be responsible for the full amount billed if the claim is rejected by your insurance.
- Please be aware that some, and perhaps all, of the services you receive may be non-covered or not considered reasonable or medically necessary by your insurance plan.

Nonpayment

- If your balance is over 60 days past due, your account will be considered delinquent and immediate payment in full will be required. Partial payments will not be accepted unless otherwise negotiated.
- Please be aware that if a balance remains unpaid, we may refer your account to a collection agency. If this takes place, you will be responsible for all collection costs that are incurred. In the event that attorney and/or court fees are required to collect your account, you will be responsible for those charges in addition to your charges from our office.
- ***Patients with accounts in bad debt will not be allowed to schedule further appointments at our office until the account balance is paid in full. Patients with accounts having a history of nonpayment are subject to being dismissed from this practice.***

Returned Check

- There is a fee of $30.00 for any checks that are returned by your bank.

Missed Appointments

- Patients who do not show up on time for an appointment, or cancel with less than 24 hours notice, will be charged a $25.00 fee. This fee must be paid before a new appointment is scheduled. Patients with three missed appointments will be asked to transfer their records to another doctor.

Minors

- All services rendered to minor patients will be the financial responsibility of the adult accompanying the minor.

Credits

- Occasionally, an overpayment may occur on your account. If this happens, we will make every effort to reimburse you if the credit balance belongs to you. In the event there is a credit balance at Augusta Urology Associates and there is an outstanding balance at Augusta Urology Surgicenter, we will transfer the credit balance to Augusta Urology Surgicenter, or vice versa.

Procedure/Surgery

- If you have a procedure and/or surgery scheduled at Augusta Urology Surgicenter, LLC or at a hospital, ***a minimum of 72 hours (3 business days) notification is required for surgery cancellation. Failure to notify us of cancellation in the required time will result in a charge of $150.00.*** This will be posted to your account.
- Please be aware that there are two separate fees regarding procedures and/or surgeries. These fees include a *physician's fee* and a *facility fee* (i.e. Surgicenter, hospital, etc). **If anesthesia is required, you will receive a separate bill from your anesthesia provider.**

Workers' Compensation

- We require written approval/authorization from your employer and/or workers' compensation carrier prior to your initial visit. If your claim is denied, you will be responsible for payment in full.

Form Payments

- Paperwork requested for our staff to complete (i.e. FMLA, disability, letters, cancer policies, etc.) costs between $5.00 and $15.00. This fee is to be paid in full before returning, faxing or mailing paperwork.

I have read and understand the financial policy of the practice and I agree to be bound by its terms.

_____	_____	_____	_____
Name of Patient or Responsible Party	Patient's Date of Birth	Signature of Patient or Responsible Party	Date

DISCLOSURE AUTHORIZATION FOR INFORMATION REQUESTS

Pursuant to the Health Insurance Portability and Accountability Act (HIPPA),
I, _____, hereby authorize the following:
Patient name

(*Please list physicians)*	*(Please list family members)*
_____	_____
_____	_____
_____	_____
_____	_____

to disclose/receive protected health information to/from Augusta Urology Associates, LLC.

- EKGs, relevant diagnostics or laboratory tests and surgeries
- Medical history
- Allergies
- Demographic and insurance information

This protected health information is being used by the practice for the purpose of urological evaluation of the patient.

This authorization shall be in force and effect until _____ or further notice.
Date

I understand that this information may include any history of acquired immunodeficiency (AIDS); sexually transmitted disease (STD); human immunodeficiency virus (HIV) infection; behavioral health services/psychiatric care; treatment for alcohol and/or drug abuse; or similar conditions.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I understand that Augusta Urology Associates, LLC will not condition my treatment on whether I provide authorization for the requested use or disclosure.

I understand that I have the right to:

- Inspect or copy my protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights.)
- Revoke this authorization in any time by written notification
- Refuse to sign this authorization

I understand that revocation is not effective to the extent that Augusta Urology Associates has relied on the use or disclosure of the protected health information.

I have received a Privacy Notice Statement. _____
Signature of patient or legal guardian

I have read, understand and have agreed upon this Disclosure Authorization.

_____ _____
Signature of patient or legal guardian Date

Augusta Urology Associates, LLC/Augusta Urology Surgicenter, LLC
Patient Demographics

Account # _____

Patient Information:

Patient Name: _____ Preferred Name: _____
Last First MI

Maiden Name: _____ Date of Birth: _____/_____/_____ Sex: ☐Male ☐ Female SSN: _____

Race: ☐African American/Black ☐ American Indian/Alaskan Native ☐Asian ☐Caucasian/White ☐Pacific Islander

Ethnicity: ☐Not Hispanic/Latino ☐Hispanic/Latino Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed

Mailing Address: _____ City: _____ State: _____
Street/P.O. Box

County: _____Zip: _____ May we leave a message on your primary phone number? ☐ Yes ☐ No

Home Phone: (_____)_____ Cell Phone: (_____)_____ Primary Phone: (_____)_____

Email Address: _____

Work Status: ☐Full-time ☐Part-time ☐ Retired ☐ Not Employed ☐ Student ☐Disabled

Occupation: _____ Employer: _____

Employer's Address: _____
Street City State Zip Code

Work Phone: (_____)_____ May we contact you at work? ☐Yes ☐ No

Emergency Contact/Legal Guardian:

Name: _____ Relationship to Patient: _____

Primary Phone: (_____)_____ Secondary Phone: (_____)_____

Insurance Information:

Primary Insurance Company: _____

Name of Insured: _____ Date of Birth: _____/_____/_____ SSN: _____

Name of Policy Holder: _____ Date of Birth: _____/_____/_____ SSN: _____

Policy Number: _____ Group Number: _____

Effective Date: _____/_____/_____ Expiration Date: _____/_____/_____ Occupation of Policy Holder: _____

Employer of Policy Holder: _____ Work Status: ☐Retired ☐Full-time ☐Part-time

Employer's Address: _____ Employer's Phone: (_____)_____

Secondary Insurance Company: _____

Name of Insured: _____ Date of Birth: _____/_____/_____ SSN: _____

Name of Policy Holder: _____ Date of Birth: _____/_____/_____ SSN: _____

Policy Number: _____ Group Number: _____

Effective Date: _____/_____/_____ Expiration Date: _____/_____/_____ Occupation of Policy Holder: _____

Employer of Policy Holder: _____ Work Status: ☐Retired ☐Full-time ☐Part-time

Employer's Address: _____ Employer's Phone: (_____)_____

Is your insurance through the Affordable Care Act? ☐Yes ☐No

What laboratory does your insurance company require to use? _____

What Physician referred you to Augusta Urology Associates? _____

Who is your Primary Care Physician? _____ Phone: (_____)_____

What pharmacy do you use? _____ City: _____

AUGUSTA UROLOGY ASSOCIATES, LLC & AUGUSTA UROLOGY SURGICENTER, LLC

Name: _____ **DOB:** _____

Chief Complaint: *What is the reason for this appointment?*

_____

Patient Sticker

HPI: *Do you have or have you ever had...*	*Has your family ever had...* **(Indicate family member in the blank)**
Cardiovascular: ☐N/A ☐Aneurysm ☐Angina/Chest Pain ☐Antibiotics before procedures ☐Artificial Heart Valve-When?_____ ☐Congestive Heart Disease ☐Coronary Heart Disease ☐Heart Attack ☐Heart Stents ☐High Blood Pressure ☐High Cholesterol ☐Pacemaker ☐Internal Defibrillator-When? _____ ☐Irregular Heartbeat ☐Peripheral Vascular Disease	☐Heart Attack-_____ ☐High Blood Pressure-_____ ☐Heart Disease-_____
Endocrine: ☐N/A ☐Diabetes ☐Thyroid Disease	☐Diabetes-_____
Gastrointestinal: ☐N/A ☐Acid Reflux ☐Colon Problems ☐Hernia ☐Liver Disease (Cirrhosis) ☐Stomach Ulcers	
Hematology: ☐N/A ☐Anemia ☐Hepatitis - Type?_____ ☐History of Blood Clots ☐HIV ☐Sickle Cell ☐Blood thinners	☐Bleeding Disorder-_____ ☐HIV-_____ ☐Hepatitis-_____
Musculo-Skeletal: ☐N/A ☐Arthritis ☐Osteoporosis ☐Degenerative Joint Disease ☐Gout	
Neurological: ☐N/A ☐Alzheimer's ☐Migraine Headaches ☐Multiple Sclerosis ☐Parkinson's ☐Seizures ☐Stroke ☐TIAs ☐Spinal Disc Disease	☐Stroke-_____
Psychological: ☐N/A ☐Anxiety ☐Depression	
Respiratory: ☐N/A ☐Asthma ☐C-PAP ☐COPD ☐Emphysema ☐Sleep Apnea ☐Shortness of Breath ☐Snores ☐Tuberculosis-Treatment? ☐Y or ☐N ☐Use oxygen at home	☐Tuberculosis-_____
Genitourinary: ☐Bladder Cancer ☐Blood in urine ☐UTI ☐Burning ☐Genital Discharge ☐Elevated PSA ☐Difficulty starting urine ☐Interstitial Cystitis ☐Kidney Stones ☐Loss of urinary control ☐Prostate Cancer ☐Stricture Disease ☐Night urination ☐ED ☐Fertility	☐Bladder Cancer-_____ ☐Prostate Cancer-_____ ☐Kidney Stones-_____

Surgical History:

Problem with anesthesia? ☐Patient ☐Family member: _____

Females: ☐N/A ☐Pregnant Last Menstrual Date: _____

Do you use tobacco? ☐Currently ☐Former ☐Never

How much daily?_____ How long?_____

Do you drink alcohol? ☐Daily ☐Once a wk ☐Rarely ☐Never

Do you use illicit drugs? ☐Currently ☐Formerly ☐Never

Assessment Form **FOR AUS STAFF USE**

Assessment date/time: _____

Scheduled procedure: _____

Prep: ☐Antibiotic ☐Enema ☐N/A

Accompanied by: _____

Safety: ☐Signed Consent ☐ID band checked

☐Bed at lowest position / locked / side rails up ☐Chair

Surgical/Procedure site marked: _____

Physical: Ht_____ Wt_____ BMI_____ ☐N/A

BP_____ Pulse_____ Respirations_____ Temp_____

Rhythm_____ SAO2_____

Skin/Mucous Membrane: ☐Pink ☐Pale ☐Flushed ☐Jaundiced

☐Warm ☐Cool ☐Dry ☐Moist ☐Turgor: ☐Good ☐Poor

M-S: Balance / Gait: ☐Steady ☐Slow ☐Unsteady

Devices: ☐Cane ☐Walker ☐W/C ☐Crutches ☐Stretcher

Prosthesis: ☐location: _____

Artificial Joints: ☐location: _____

☐Prophylactic antibiotic prior to procedures

Emotional: ☐Alert ☐Oriented ☐Cooperative ☐Anxious

☐Confused / Disoriented ☐Forgetful ☐Calm

☐Usual (altered) mental status

Functional: ☐N/A ☐Glasses ☐Contacts

☐Glaucoma ☐Macular Degeneration

☐Dentures ↑↓ ☐Partial ↑↓ ☐Bridges ↑↓ ☐Loose teeth ↑↓

☐Hearing loss ☐Hearing Aid: R L

Nutritional Status: Time of last PO intake_____

Genitourinary: Pain location_____

☐Catheter: Size _____ ☐BPH ☐BOO ☐PSA level: _____

Other_____

RN Signature: _____

ASA Class: _____

Surgeon: _____

Anesthesia: _____

AUGUSTA UROLOGY ASSOCIATES, LLC & AUGUSTA UROLOGY SURGICENTER, LLC

Medication Reconciliation List

☐ **Latex Allergy**_____

☐ **Food Allergy**_____

Medication Allergies:

Medication	Reaction	Medication	Reaction	Medication	Reaction

Current Medications: To include over the counter medicines and herbal supplements

Patient to Complete				Nurse to Complete		
Name of Medication	Dosage (Amount taken)	Route (How taken)	Frequency (How often)	Last Dose	Continue	Stop

New Prescriptions: Nurse to Complete

Nurse Signature: _____

Date: _____ **Physician Signature:** _____

Please take this medication list to your next doctor's visit. It is recommended that you bring a list of your current medications to each medical appointment.

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