

Southeast Texas Urology Associates, L.L.P.

Date: _____

Referring/Primary Physician: _____

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Gender: M / F Marital Status (circle one) S M D W

Patient Phone #: _____ Cell#: _____ Pager#: _____

Nearest Relative: Name: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Emergency Contact other than Nearest Relative: Name: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____

Patient Social Security#: _____

Patient Employer: _____

Address: _____ State: _____ Zip: _____

Employment Status: _____ Phone: _____

Responsible Party Information (if different from patient):

Name: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Relation to patient: _____ Social Security #: _____

Date of Birth: _____ Employer: _____ Work#: _____

Work Address: _____ City: _____ State: _____ Zip: _____

Insurance Information:

Primary Insurance Company: _____

Secondary Insurance Company: _____

It will be my responsibility to call and get results from all lab and xrays performed through this office.

Signature _____

I authorize all medical and/or surgical treatment to be rendered by Dr. J. Denton Harris, Dr. John Henderson and Dr. Steven A. Socher and I assume financial responsibility. I assign all benefits to be paid to Southeast Texas Urology Associates - Dr. J. Denton Harris, Dr. John Henderson and Dr. Steven A. Socher under my medical Insurance Program and give my authorization to release records if necessary including DX and treatment to Insurance Company, physicians. etc.

Signature _____

Date _____

Account # _____

PATIENT NAME: _____ Age _____

Reason for today's visit: _____

Medical History:

1. Current Medications: _____

2. Are you presently taking: (circle) Coumadin - Aspirin - Ecotrin - Persantine - Glucophage

Inhalers - Ticlid - Plavix - St. John's Wort

3. Have you had a (Circle One) Heart Attack Yes/No Stroke Yes/No
Diabetes Yes/No Emphysema/Asthma Yes/No

4. Other Medical Problems: _____

5. List Previous surgeries: _____

6. Allergies: _____

Family History of: (Please Circle) Kidney Cancer Yes/No Bladder Cancer Yes/No

7. Occupation: _____

8. Tobacco Use: (Please Circle) Cigarettes Yes/No

Please Circle Yes or No to Each Symptom

Circle Symptoms that you have experienced recently:

- | | | |
|------------------------------|------------------------------------|------------------------|
| Y/N Fever | Y/N Urethral discharge | Y/N Boils |
| Y/N Chills | Y/N Blood in urine | Y/N Hepatitis |
| Y/N Weight Loss | Y/N Leaking of urine | Y/N Reflux |
| Y/N Malaise (feeling poorly) | Y/N Urgency to void | Y/N Glaucoma |
| Y/N Abdominal pain | Y/N Voiding at night | Y/N Wheezing |
| Y/N Constipation | Y/N Slow stream | Y/N Cough |
| Y/N Diarrhea | Y/N Difficulty starting stream | Y/N Thyroid disease |
| Y/N Nausea | Y/N Incomplete emptying of bladder | Y/N Chest pain |
| Y/N Vomiting | Y/N Masses protruding from vagina | Y/N Varicose veins |
| Y/N Swelling of legs | Y/N Straining to urinate | Y/N Multiple sclerosis |
| Y/N Lesions on genitalia | Y/N Burning with urination | Y/N Migraines |
| Y/N Vaginal bleeding | Y/N Loss of sexual interest | Y/N Dizziness |
| Y/N Kidney (flank) pain | Y/N Painful intercourse | Y/N Bleeding disorder |
| Y/N Shortness of breath | Y/N Back pain/Surgery | Y/N Immune disorder |
| Y/N Vaginal discharge | Y/N Skin rash | Y/N Joint problems |

MEDICARE CLAIMS

Important Change In Lifetime Beneficiary Claim Authorization ("Signature on File") Requirements

To ensure informed consent of Medicare beneficiaries to release medical information and Medicare payment information to third party carriers (e.g. Medicaid, MediCal, private Medicare supplement insurers, etc.) physicians and suppliers must have their patients sign and date an authorization statement worded as follows:

Name of Beneficiary _____

HIC Number (Medicare Number) _____

I request that payment of authorized Medicare benefits be made either to me or on my behalf to (name of physician/supplier) for any services furnished to me by (that physician/supplier). I authorize any holder of medical information about me to be released to the centers for Medicare & Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payments be made and authorize release of medical information necessary to pay this claim. If item 9 on the CMS 1500 claim form is completed, my signature authorized releasing of the information to the insurance agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Beneficiary Signature _____

Date _____

Physicians and suppliers should ensure that new patient's "signature on file" authorizations contain this language. Established patient's authorization should be revised and resigned when the patient is next seen.

Once the physician/supplier has obtained the patient's one time authorization, he may submit any later Medicare claims on either an assigned or unassigned basis, without obtaining any additional signature of the patient.

In submitting claims, he should indicate the patient's signature space "signature on file"

In submitting claims under the signature agreement procedure, physicians and suppliers undertake to:

1. Complete and submit promptly the appropriate Medicare billing form for all services covered by the request for payment – even those in which the physician has not accepted assignment.
2. Incorporate by stamp or otherwise, information to the following effect on any bill they send to Medicare patients; "Do not use this bill for claiming Medicare benefits. A claim has been or will be submitted to Medicare on your behalf" this requirement is necessary to prevent patients from submitting duplicate claims.
3. Cancel the authorization on request by the patient.
4. Make the patient signature file available for carrier inspection upon request.

Acknowledgment of Review of Notice of Privacy Practices

I have reviewed this office's 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.

Signature of Patient or Personal Representative

Date

Name of Patient or Personal Representative

Description of Personal Representative's Authority

The physician may discuss my medical history with the following people:

_____	Relationship to Patient
_____	Relationship to Patient
_____	Relationship to Patient
_____	Relationship to Patient

**Statement of Patient Financial Responsibility
Southeast Texas Urology Associates, L.L.P.**

The doctors of Southeast Texas Urology appreciate the confidence you have shown in choosing them to provide your urological care. We are committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

Patient Financial Responsibilities

1. The patient (or patient's guardian, if a minor) is ultimately responsible for the payment for their treatment and care. You are responsible for knowing your own plan benefits and coverage.
2. We are pleased to assist you by billing to our contracted insurers. However, the patient is required to provide us with the most correct and updated information about their insurance, and will be responsible for any charges incurred if the information provided is not correct or updated.
3. Patients are responsible for the payment of co-pays, coinsurance, deductible, and all other procedures or treatment not covered by their insurance plan. Payment is due prior to any surgery or at the time of service for office encounters. For your convenience, we accept cash, check, and most major credit cards.
4. If you do not know your co-pay we will collect a minimum fee of \$30.00. Our billing department will bill or credit your account accordingly after your insurance pays their portion. If you are not prepared or unable to pay your co-payment at the time of your visit, we will kindly reschedule your appointment for a more convenient time.
5. Overpayment will be refunded after all charges have been processed and paid by your insurance company. A refund check will be written and mailed within 15 days of your verbal or written request.
6. Patients may incur, and are responsible for the payment of additional charges at the discretion of Southeast Texas Urology. These charges may include (but are not limited to):
 - Charge for returned checks.
 - Charge for copying and distribution of patient medical records.
 - Charge for extensive forms completion.
 - Any costs associated with collection of patient balances.
7. If you have managed care insurance, it is your responsibility to obtain a referral. As there are hundreds of insurance plans and we do not participate with all, you need to make sure Southeast Texas Urology is part of your network.
8. Patient accounts 90 days past due will be referred to an outside billing service.

I have read, understand, and agree to the provisions of the Patient Financial Responsibility Form.

Signature of Patient or Guardian

Date

Print Signature

Date of Birth

Professional services for lab and radiology readings will be billed separately by a third party.

Patient Name _____

Race-Circle One

- | | | |
|-------------------|----------------|------------------------|
| African | European | Native Hawaiian |
| African American | Filipino | Nepalese |
| Alaskan Native | Haitian | North African |
| American Indian | Hispanic | Okinawan |
| Arab | Hmong | Other Pacific Islander |
| Asian | Indonesian | Other Race |
| Asian Indian | Iwo Jiman | Pakistani |
| Bahamian | Jamaican | Polynesian |
| Bangladeshi | Japanese | Singaporean |
| Barbadian | Korean | Sri Lankan |
| Bhutanese | Laotian | Taiwanese |
| Black | Medagascar | Thai |
| Burmese | Malaysian | Tobagoan |
| Cambodian | Maldivian | Trinidadian |
| Chinese | Melanesian | Vietnamese |
| Dominica Islander | Micronesian | West Indian |
| Dominican | Middle Eastern | White |

If Hispanic, please circle ethnicity.

Central American, Cuban, Dominican, Latin American, Mexican, Puerto Rican,
South American, or Spaniard

Preferred Language _____

Nurse Practitioner Consent

This practice has on staff nurse practitioners to assist in the delivery of urology care. A nurse practitioner is not a doctor. A nurse practitioner is a registered nurse who has received advanced education and training in the provision of health care. A nurse practitioner can diagnosis, treat, and monitor common acute and chronic diseases as well as provide health maintenance care. She works under the direct supervision of a physician.

I have read the above and hereby consent to the services of a nurse practitioner for my health care needs. I understand that at any time I can refuse to see the nurse practitioner and request to see a physician.

Signature of patient or legal guardian

Date

Relationship to patient (if legal guardian)