Date:_____

Southeast Texas Urology Associates, L.L.P.

Referring/Primary Physician:_____

Name: _____ Social Security #:_____

Mailing Address:_____

City:_____ State:_____ Zip:_____

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

Home #:_____ Work #: _____ Cell #:_____

Email:_____

Emergency Contact (other than Nearest Relative): Name:_____ Relationship:_____

Address:_____ Phone #:_____

City:_____ State:_____ Zip:_____

Nearest Relative: Name:_____ Relationship: _____

Address:_____ Phone #:_____

City:_____ State:_____ Zip:_____

Patient Employer:_____

Address:_____ State:_____ Zip:_____

Phone #:_____ Employment Status:_____

Responsible Party Information (if different from patient):

Name:_____ Relationship:_____

Date of Birth:_____ Phone #:_____

Address:_____

City:_____ State:_____ Zip:_____

Insurance Information:

Primary Insurance Company:_____

Secondary Insurance Company:_____

It will be my responsibility to call for results and all lab and x-rays through this office if not informed in a timely manner.

Signature_____

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

Signature_____

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. Amounts collected are estimates only. Insurance companies do not guarantee benefits. After the claim is filed you may be due a refund or owe additional funds. 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.

Southeast Texas Urology Associates, L.L.P.

Name: _____ Age:_____ Date of Birth:_____

Allergies: _____

***Do you drink alcohol?**

Yes / No

Social Light Moderate

Do you smoke/dip?

Yes / No

How much? _____

How long? _____

Did you ever smoke?

Yes / No

When did you quit? _____

Height _____

Weight _____

Pneumonia Immunization

Yes / No When: _____

Last Colonoscopy:

_____

Preferred Pharmacy:_____ **Mail order:**_____

Check any illness the patient or blood relative had.	Patient	Mother	Father	Sister	Brother
Reaction to Anesthesia					
Emphysema/ Asthma					
Kidney Stones					
Hepatitis					
Bronchitis					
Heart Attack					
High Blood Pressure					
Congestive Heart Failure					
Heart Disease					
Stomach ulcers/ GERO					
Diabetes					
Bleeding Problems					
Kidney Problems					
Thyroid Disease					
Stroke					
Cancer Type:_____					
Kidney Cancer					
Bladder Cancer					
Prostate Cancer					
High Cholesterol					
Gout					

Surgeries: **Date**

_____

_____

_____

_____

_____

Medications:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Do you have access to your Patient Portal?

Yes / No

Email:_____

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)

Prostate Cancer **Yes/No** Kidney Cancer **Yes/No** Bladder Cancer **Yes/No**

7. Occupation: _____
8. Tobacco Use: (Please Circle) Cigarettes/Cigar **Yes/No** Dipping/Chewing **Yes/No**

Please Circle Yes or No to Each Symptom

Y/N Fever
Y/N Chills
Y/N Weight Loss
Y/N Weight Gain
Y/N Night Sweats
Y/N Malaise (feeling poorly)
Y/N Abdominal Pain
Y/N Constipation
Y/N Diarrhea
Y/N Nausea
Y/N Vomiting
Y/N Swelling of Legs
Y/N Chest Pain
Y/N Irregular Heartbeat
Y/N Vaginal Bleeding
Y/N Kidney (flank) Pain
Y/N Shortness of Breath
Y/N Pelvic Pain
Y/N Vaginal Discharge
Y/N Vaginal Delivery
If yes, how many_____

Y/N Urethral Discharge
Y/N Blood in Urine
Y/N Leaking of Urine
Y/N Urgency to Void
Y/N Voiding at Night
Y/N Slow Stream
Y/N Difficulty Starting Stream
Y/N Incomplete Emptying of Bladder
Y/N Masses Protruding from Vagina
Y/N Straining to Urinate
Y/N Burning with Urination
Y/N Loss of Sexual Interest
Y/N Painful Intercourse
Y/N Back Pain/Surgery
Y/N Sore Muscles
Y/N Arthritis
Y/N Hepatitis
Y/N Reflux
Y/N Glaucoma
Y/N Blurry Vision
Y/N Cataracts

Y/N Blind
Y/N Hearing Loss
Y/N Nasal Stuffiness
Y/N Dry Mouth
Y/N Sore Throat
Y/N Rash
Y/N Dry Skin
Y/N Bruising
Y/N Lesions/Ulcers
Y/N Dizziness
Y/N Forgetfulness
Y/N Migraines
Y/N Loss of Balance
Y/N Depression
Y/N Swollen Glands
Y/N Bleeds Easily
Y/N Blood Clots
Y/N Wheezing
Y/N Cough
Y/N Joint Problems

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

Patient Name _____

Ethnicity-Circle One

Central American	Hispanic or Latino	Puerto Rican
Cuban	Latin American	South American
Declined to Answer	Mexican	Spaniard
Dominican	Not Hispanic or Latin	

Race-Circle One

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

Preferred Language _____

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 benfits 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.