



UroCare

Practice Limited to Urology
and Urological Surgery

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Established Patient Information: Please print and complete all entries.

Legal Name: _____ Social Security#: _____

Date of Birth _____ Height _____ Weight _____ Sex: M or F

Complete Address: _____

Home Phone: _____ Work Phone _____

Mobile Phone: _____ E-Mail: _____

Pharmacy: _____ Phone: _____ Fax: _____

May we call you at work? Yes ___ No ___ May we leave detailed messages on voicemail? Yes ___ No ___

May we discuss your medical information with family members? Yes ___ No ___

If yes, Name _____ Phone _____

Additional Names _____ Phone _____

Referring/Primary Physician _____ Phone _____

Parent/Guardian Name _____ Relationship to Patient _____

Next of Kin and Emergency Contact Information

Name _____ Relationship _____

Home Phone _____ Work Phone _____

I have read all of the information on the UroCare Billing Policy that was provided to me and acknowledge my financial responsibilities. Initial: _____

I understand and agree, regardless of my insurance status, I am ultimately responsible for my co-pay, deductible, and any non-covered charges. Initial: _____

I was provided with Notice of Privacy Practice, and aware that Urocare send appointment reminder cards. Initial: _____

I certify that to the best of my knowledge, this information is correct and true. I will notify this office in case of any changes to my health or any of the information I have provided. I hereby authorize the release of all pertinent medical information to insurance carriers for the purpose of payment.

Signature: _____ Date: _____

(PLEASE PROCEED TO THE NEXT PAGE)



UROCARE BILLING POLICY

PATIENT FINANCIAL RESPONSIBILITY

1. If insurance card is unavailable, payment is required in full at time of service.
2. Payment can be made with cash, check, Visa, MasterCard, and debit cards.
3. ***The bill for services rendered is your responsibility, the patient.*** We participate in many managed care plans, will file and make attempt to collect our allowable fees, however, if they do not pay in a timely fashion ***it is ultimately your responsibility*** and we will expect payment from you.
4. If you are covered by an insurance plan, you must provide:
 - a. Co-payment at time of service.
 - b. Valid insurance card and verification at or before date of service.
 - c. If you have HMO insurance, and a referral is required, it is your responsibility to bring it at time of service.

BILLING POLICY

1. **There will be a \$25.00 service charge (plus bank charges) for any returned check.**
2. **You will be charged \$50.00 if you do not show up or cancel your appointment within 24 hours of a scheduled office visit or follow up.**
3. **You will be charged \$75.00 if you do not show up or cancel your appointment within 24 hours of a scheduled procedure.**

For patients who are underage, non-emergent treatment will be denied unless the adult accompanying the minor accepts responsibility.

UROCARE NOTICE OF PRIVACY PRACTICES

We are to inform you that Urocare send out appointment reminders to all patients in a form of a post card.

We are required by law to provide you with a notice that explains our privacy practices with regard to your medical information and how we may use and disclose your protected health information for treatment, payment, and for health care operations, as well as for other purposes that are permitted or required by law. You have certain rights regarding the privacy of your protected health information that is described in the privacy notice.