

COAST UROLOGICAL MEDICAL GROUP, INC.

PLEASE PRINT AND COMPLETE ALL SECTIONS

PATIENT'S PERSONAL INFORMATION:

MARITAL STATUS: SINGLE MARRIED DIVORCED WIDOWED

LAST NAME: _____ FIRST NAME: _____ MIDDLE INITIAL: _____

HOME ADDRESS: _____ CITY: _____ ZIP CODE: _____

PRIMARY PHONE # () _____ SECONDARY PHONE # () _____

DATE OF BIRTH: _____ SOCIAL SECURITY # _____ SEX: MALE _____ FEMALE _____

EMAIL: _____

EMPLOYER: _____ OCCUPATION: _____

SPOUSE'S NAME: _____ DATE OF BIRTH: _____ SOCIAL SECURITY # _____

IF PATIENT IS A MINOR OR STUDENT:

MOTHER'S NAME: _____ DATE OF BIRTH: _____ SOCIAL SECURITY # _____

[] CHECK IF HOME ADDRESS IS SAME AS PATIENT / IF NOT: _____

EMPLOYER: _____ OCCUPATION: _____ CELL PHONE # () _____

FATHER'S NAME: _____ DATE OF BIRTH: _____ SOCIAL SECURITY # _____

[] CHECK IF HOME ADDRESS IS SAME AS PATIENT / IF NOT: _____

EMPLOYER: _____ OCCUPATION: _____ CELL PHONE # () _____

PATIENT'S INSURANCE INFORMATION:

SPECIALIST CO-PAY: _____ VAS CO-PAY: _____

PRIMARY INSURANCE: _____ INSURANCE ID # _____ GROUP # _____

***PRIMARY POLICY HOLDER:** _____ **DATE OF BIRTH:** _____

RELATIONSHIP TO SUBSCRIBER: SELF SPOUSE CHILD OTHER _____ CELL PHONE # () _____

SECONDARY INSURANCE: _____ INSURANCE ID # _____ GROUP # _____

***SECONDARY POLICY HOLDER:** _____ **DATE OF BIRTH:** _____

RELATIONSHIP TO SUBSCRIBER: SELF SPOUSE CHILD OTHER _____ CELL PHONE # () _____

ADDITIONAL INFORMATION:

REFERRING PHYSICIAN: _____ PHONE # () _____

PRIMARY CARE PHYSICIAN: _____ PHONE # () _____

ALTERNATE CONTACT: _____ RELATIONSHIP: _____

(Outside of Home)

ADDRESS: _____ PHONE # () _____

PREFERRED PHARMACY: _____ PHONE # () _____

ASSIGNMENT OF BENEFITS AND FINANCIAL AGREEMENT:

I hereby give lifetime authorization for payment of insurance benefits to be made directly to Coast Urological Medical Group, Inc., and any assisting physicians, for services rendered. I understand that I am responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection, and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits; and agree that a photocopy of this agreement shall be as valid as the original. No guarantees have been made to me regarding the outcome of care.

Date: _____ **Signature:** _____

Information provided above is still current as of the following date:

Date: _____ Signature: _____

Information provided above is still current as of the following date:

Date: _____ Signature: _____



COAST UROLOGICAL MEDICAL GROUP

William T. Naftel, M.D. Michael Norris, M.D. Stephen A. Hightower, M.D. Alexa Y. Chai, M.D.
Diplomates, American Board of Urology

Date: _____

PATIENT HISTORY

WELCOME TO OUR PRACTICE. TO PROVIDE YOU WITH THE BEST CARE POSSIBLE, PLEASE PROVIDE THE FOLLOWING INFORMATION WHICH WILL BE CONFIDENTIAL AND RELEASE ONLY WITH YOUR WRITTEN PERMISSION.

PLEASE PRINT:

Last Name: _____ First Name: _____ Middle Initial: _____

Chief Complaint: _____ Age: _____

Brief History of Problem: _____

LIST THE OPERATIONS YOU HAVE HAD: _____

PAST MEDICAL HISTORY (PLEASE CHECK YES OR NO):

	Yes	No		Yes	No		Yes	No		Yes	No
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	Mumps	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Gynecologic Problems	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	Blood in Urine	<input type="checkbox"/>	<input type="checkbox"/>
Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Lung Problems	<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	Blood Clots	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Disorders	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>			
Bladder/Kidney Infection	<input type="checkbox"/>	<input type="checkbox"/>									

Have you ever had a serious accident? No _____ Yes _____, Please describe:

Have you ever had a blood transfusion? No _____ Yes _____ If "Yes", what year? _____

(CONTINUED ON SECOND PAGE)

REVIEW OF SYMPTOMS: (CHECK ALL THOSE THAT ARE APPLICABLE)

GENERAL: Fever ____ Chills ____ Weight Loss ____ Weakness ____

SKIN: Rash ____ Itching ____

HEMATOPOIETIC: Bruising ____ Bleeding ____ Anemia ____

HEENT: Vision Change ____ Double Vision ____ Glaucoma ____ Vertigo ____ Hearing Problems ____

RESPIRATORY: Cough ____ Coughing Blood ____ Shortness of Breath ____ Infections ____

CARDIOVASCULAR: Chest Pain ____ Murmurs ____ Pain in Legs with Walking ____ Swelling in the Legs ____

G.I.: Constipation ____ Diarrhea ____ Bleeding ____ Hemorrhoids ____ Indigestion ____ Hepatitis ____

MUSCULOSKELETAL: Joint Pain ____ Weakness ____ Back Pain ____ Cramps ____

NEUROLOGIC: Headache ____ Dizziness ____ Seizures ____ Blackouts ____ Depression ____

Alcohol (aver./day) _____

Caffeine (aver./day) _____

Tobacco (aver./day) _____

Educational Level _____

Number of Children _____

Recreational Drugs _____

FAMILY HISTORY:

Member	Living	Dead	Illness/Cause of Death or State of Health	Any Cancer of Prostate, Diabetes, or Kidney Stones?
Father				
Mother				
Brother				
Brother				
Sister				
Sister				

Is there anything else regarding your health that you would like the Doctor to know?



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ELIGIBILITY & BENEFITS WAIVER

I, _____, hereby certify that I am eligible for _____ insurance effective _____.

I have chosen Dr. _____ as my urologist. I understand that if I am found to be ineligible, or if the services rendered are found to be non-covered benefits under my plan, I am responsible for all costs incurred in the delivery of my medical services and will pay these charges within thirty (30) days of billing.

PATIENT SIGNATURE (Parent or Guardian)

DATE

WITNESS SIGNATURE

DATE



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Patient Responsibility Agreement

Patient Name: _____ DOB: _____

Insurance Company: _____ Subscriber ID: _____

Patient/Guardian Signature: _____ Date: _____

BILLING STATEMENT

As a courtesy to our patients, we will bill your insurance company for services rendered. Contracts with insurance companies vary greatly and often times providers are considered out of network for many insurance plans. If we are NOT a network provider for your insurance plan, you will be responsible for the balance of the contracted rate remaining after payment is made by your insurance company. We will apply the appropriate payments and adjustments to your account before the remaining balance is billed to you. **Deductibles, co-payments and any denied charges are always the responsibility of the patient.** For additional information regarding your deductible or co-payment responsibility, you can contact your insurance carrier directly.



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FINANCIAL POLICY OF PRACTICE

OUR PRACTICE FINANCIAL POLICY

We are dedicated to providing you with the best possible care and service and regard your understanding of our financial policies as an element of your care and treatment. To assist you, we have the following financial policy. If you have any questions, please feel free to discuss them with our staff.

Unless other arrangements have been made in advance by either yourself or your health coverage carrier, full payment is due at the time of your service.

Co-payments are accepted in the form of cash or check only. For your convenience, we accept all major credit cards when making a payment towards a previous balance, co-insurance or deductible.

YOUR INSURANCE

We have made prior arrangements with many insurers and other health plans. We will bill those plans with whom we have an agreement and will collect any required co-payment, co-insurance and/or deductible at the time of service. The co-payment will be collected when you arrive for your appointment. **In the event your health plan determines a service to be “not covered,” you will be responsible for the complete charge.** In that event, we will bill you and payment is due upon receipt of that statement. A late fee of \$25 will be assessed if payment is not received within 14 days of the statement due date. Any balance which remains unpaid after 30 days may be referred to a collections agency.

We will also bill your health plan for all services we provide in the hospital. Any balance due is your responsibility and is due upon receipt of a statement from our office.

MISSED APPOINTMENTS

In order to provide the best possible service and availability to all our patients, we ask that you call us as early as possible if you know you will need to reschedule your appointment. Failure to do so may result in a fee for the missed appointment.

DELINQUENT ACCOUNTS

Any account balance unpaid beyond 90 days is considered past due. Once an account becomes delinquent, the account may be charged an additional 25% of the past due principle account balance. If the account continues to remain delinquent, it will be subject to outside collection agency action.

**I have read and understand the financial policy of the practice and I agree to be bound by its terms.
I also understand and agree that such terms may be amended from time-to-time by the practice.**

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY IF MINOR X	TODAY'S DATE
PRINT NAME OF THE PATIENT X	



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FINANCIAL FEES OF PRACTICE

To OUR PATIENTS

We are dedicated to providing you with the best possible care and service and regard your understanding of our financial policies as an element of your care and treatment.

We understand that appointments may need to be rescheduled, but a courtesy call **24 hours in advance** will allow us to accommodate another patient in that clinic time slot.

A courtesy of **72 hours in advance** applies for procedures performed both in our office and at the hospital. Much preparation and effort goes into scheduling urologic procedures affecting our physicians, the hospital, your internist and the various ancillary services.

As such, the following fees have been instituted. These fees are not billable to your insurance and payment will be required prior to the next scheduled visit. If you have any questions, we are happy to discuss them with you.

THE FOLLOWING FEES WILL BE CHARGED:

Missed Appointments \$ 40.00	Short Notice Cancellations \$ 25.00 (Less than 24 hours' notice)
Missed Procedure \$ 150.00	Short Notice Procedure Cancellation \$ 100.00 (Less than 72 hours' notice)
Missed Surgery \$ 250.00	Short Notice Surgery Cancellations \$ 150.00 (Less than 72 hours' notice)
Copying Medical Records \$ 30.00 (minimum charge)	Mailing of Prescriptions \$ 10.00 Handling Charge (No charge for office pick up)
Dictated Physician Letter \$ 50.00	Non-Sufficient Funds Check \$ 10.00
Forms-EDD, FMLA, DMV, Jury Duty \$ 25.00	Billing Records \$ 15.00
Prior Authorization for Prescriptions \$ 25.00	

I understand that all fees listed above are NOT covered by insurance and must be paid in full prior to any new or rescheduled appointment, procedure or surgery.

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

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY IF MINOR

X

PRINT NAME OF THE PATIENT

X

TODAY'S DATE