DOCS
DOCTORS OF CLINICAL SPECIALTIES

515 W. S.R. 434 Suite 302
Longwood, FL 32750

UROLOGY CONSULTANTS

## Patient Information

Today's Date: _____ Date of Last Physical Exam: _____

Last Name: _____ First Name: _____

Address: _____ City, State, Zip: _____

Primary Phone # (_____)_____-_____ Secondary Phone # (_____)_____-_____

SSN: _____ DOB: _____ Age: _____ Sex: M / F / ___

Marital Status: _____ Race: _____ Ethnicity: _____

E-Mail Address : _____

Emergency Contact Name & Phone Number: _____

How were you referred to our office? (Please list first & last name) _____

Who is your family doctor? (Please list first & last name) _____

## Patient Financial Information

How will you be paying for your services today? ☐ Insurance ☐ Self Pay ☐ Worker's Comp ☐ Other

Primary Insurance Carrier _____ Benefits Phone# _____

ID # _____ Group# _____

Policy Holder Name : _____ Policy Holder DOB _____

Secondary Insurance Carrier _____ Benefits Phone# _____

ID #_____ Group# _____

Policy Holder Name : _____ Policy Holder DOB _____

**Patient's Signature** _____ **Date** _____

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PATIENT NAME: _____

**Please provide us with the following information so your prescription (if any) may be expeditiously sent to the pharmacy of your choice electronically.** Our system communicates with thousands of pharmacies nationwide, we would like to make sure if a prescription is assigned to you it **Reaches** the pharmacy of your choice.

**YOUR LOCAL PHARMACY**

Name: _____

Phone number: _____

Address: _____

City: _____ Zip code: _____

**LONG TERM PHARMACY (90 DAYS OR MORE)**

Name: _____

Phone number: _____

Address: _____

City:_____ Zip code: _____

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## RECEIPT OF PRIVACY AND FINANCIAL POLICIES

By signing below I acknowledge that I have received, read and been given the opportunity to ask questions regarding these policies. By signing, I agree to the terms and conditions contained in the policies. A written notice is required to terminate the agreement of these policies.i am aware that the termination of these policies may result in the dismissal from Urology Consultants.

PRINT NAME: _____ DOB: _____

SIGNATURE: _____ DATE: _____

## RELEASE OF CONFIDENTIAL INFORMATION

It is the policy of Urology Consultants not to release any protected information regarding your medical and your personal information to anyone except those indicated in our Privacy policy required by Law. entities receiving information for the continuity of care may include your Primary care Physicians, Pharmacies, Insurance companies, and other health care providers referred. Your written permission is needed in order for the following individuals to obtain information regardless of who is financially responsible for your account: **spouses, children or other family members.**

Please list below the names of individuals that you authorize us to disclose your medical information with.

- ❑ I **DO NOT** wish you to discuss my medical information with anyone except those outlined in the Privacy Policy and myself.
- ❑ You may discuss my medical information with the following individuals:

  1. _____
  2. _____

- ❑ I authorized Urology Consultants to leave detailed messages on my home phone or cell phone number, answering machine as needed for the following purposes: appointments, insurance/ billing inquiries, test results, etc. I understand that someone other than myself may hear this information and I will not hold Urology Consultants responsible for information left via telephone message systems.

PRINT NAME: _____ DOB: _____

SIGNATURE: _____ DATE: _____

**This form will expire one year from the date signed. Please note you will be required to complete this form yearly.**

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# FINANCIAL POLICY

Thank you for choosing us as your healthcare provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy which we require you to read and sign prior to any treatment. All patients must complete all required paperwork before seeing the doctor.

**PAYMENTS IS DUE AT THE TIME OF SERVICE, WE ACCEPT CASH, CHECKS, OR CREDIT CARDS.** Services are required to be paid at the time of service. Pre-payment options are available and are encouraged in order to avoid any additional charges. Patient's will be responsible for any fees incurred from collection agencies and/or legal services hired by urology consultants to secure payments for services.

**INSURANCE**

With prior arrangements we will file to your insurance company. However, we do require the patients percentage of the bill to be paid at the time of service. The balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you give a copy of your insurance card. Your insurance policy is a contract between you and your insurance company. If your insurance company has not paid your account in full within 45 days, you will be responsible for the bill within 10 days of receipt of your statement. Please be aware that some, and perhaps all, of the services provided may be NON-COVERED SERVICES and not considered reasonable by your insurance policy. Regarding insurance plans in which we are a participating provider, all copays are due at the time of treatment. In the event that your insurance coverage changes to a plan where we are not participating providers it is the responsibility of the patient to pay for services rendered at the time of the appointment.

**USUAL AND CUSTOMARY RATES**

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

**MANAGED CARE & REFERRALS**

Patients are responsible for ensuring that they are seeing a physician which is listed in their Provider Directory. Failure to do so would result in the patient being responsible for charges incurred. It is not the responsibility of Urology Consultants to ensure we are providers. Our main concern is the health of our patients. Patients that are members of an HMO are required to secure a referral from their Primary Care Physician (PCP) before scheduling an appointment with a specialist. To accommodate our patients in informing the PCP, medical records will be sent after each visit as well as a faxed request 2 days prior to follow up visits. If the referral is not secured by our office the day prior to follow up visits, the patient will be notified and will be given the following options: 1. Reschedule Appointment, 2. Keep Appointment and pay for services, 3. Secure his referral from the PCP. **To expedite the referral process, patients are encouraged to inform their PCP'S office of any follow up visits, procedures and/ or surgery.**

**BENEFITS ASSIGNMENT/ RELEASE OF INFORMATION/ MEDIGAP**

I, hereby assign all medical and/ or surgical benefits to include major benefits to which I am entitled to Urology Consultants. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.

A photocopy of my insurance card is to be considered as valid as the original. i , hereby authorize Urology Consultants to release all information necessary, including medical records and **HIV related medical record documentation.** If any, to any third party payer to whom the patient has directed the bill be sent to secure payment. My signature constitutes a lifetime authorization. I authorize the doctors to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

☐ I prefer that Urology Consultants contact me before any HIV related medical records documentation be given to any including my insurance company. In which case i will be responsible for any changes incurred from your office within 10 days after contacting me. I do understand that information regarding HIV results, therapy, counseling, etc. obtained by Urology Consultants will be released to the health department as required by law. I Request that payment of authorized **MEDIGAP** benefits be made either to me or on my behalf to Urology Consultants for any services furnished me by that physician. I authorize any holder of medical information about me to release to my insurance company any information needed to determine these benefits or the benefits payable for related services. My signature constitutes a lifetime authorization.

NAME: _____

SIGNATURE OF PATIENT: _____ DATE: _____

SIGNATURE OF GUARDIAN: _____ DATE: _____

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Urology Consultants

Dear Patient,

On July 1, 2020, a new State Law went into effect requiring a written consent be on file for any pelvic exam, rectal exam or any procedure involving the male or female genitals.

- Such exams/procedures are an integral part of urologic care and evaluation.
- Such exams/procedures will always be announced and can always be refused despite this consent being on file.
- Such exams/procedures will ONLY be performed by Dr. Brooks, his nursing staff, his ultrasound technician or his urodynamics technicians. There will not be any students performing pelvic exams or pelvic procedures.

I _____ (D.O.B. - _____/_____/_____) grant consent for Dr.Brooks or his designees as stated above, to perform pelvic exams or pelvic procedures as necessary during the course of my care today and going forward. I can refuse such exams/procedures at any time.

Patient signature: _____ Date:_____