Review of Systems

Do you or have you had any problems related to the following symptoms? Circle **Y**es or **N**o.
Please explain any Yes answers in space provided.

Name_____ **Date**_____

Constitutional:

Fever	Y	N
Chills	Y	N
Weight Loss	Y	N

Eyes:

Blurred vision	Y	N
Double vision	Y	N
Cataracts	Y	N

Ears/Nose/Mouth/Throat:

Hearing Loss	Y	N
Nasal Stuffiness	Y	N
Sore Throat	Y	N

Cardiovascular:

Chest Pain	Y	N
Swollen Ankles	Y	N
Irregular Heartbeat	Y	N

Respiratory:

Shortness of Breath	Y	N
Wheezing	Y	N
Chronic Cough	Y	N

Gastrointestinal:

Abdominal pain	Y	N
Nausea/vomiting	Y	N
Change in Bowels	Y	N

Musculoskeletal:

Chronic Back Pain	Y	N
Chronic Neck Pain	Y	N
Sore Muscles	Y	N

Integumentary/Skin:

Rash	Y	N
Persistent Itching	Y	N
Skin Cancer History	Y	N

Neurological:

Numbness	Y	N
Tingling	Y	N
Dizziness	Y	N

Hematologic:

Swollen Glands	Y	N
Abnormal Bleeding	Y	N
Transfusion History	Y	N

Genitourinary:

Incontinence	Y	N
Pain with Urination	Y	N
Blood in Urine	Y	N

PATIENT INFORMATION RECORD

Name: _____

Reason(s) for visit_____

Allergies:

_____

_____

_____

Medications and dose:

_____

_____

_____

Surgeries/Hospitalizations:

_____

_____

_____

Medical History (all health problems):

_____

_____

_____

Family Medical History

	Heart Problems (please describe)	Cancer (please describe)	Other Major Problems
Mother			
Father			
Sister			
Brother			

Smoking Status: Current Smoker How much? _____

Former Smoker When did you quit? _____

Never Smoked

Alcohol Status: Do you drink alcohol? YES NO How much? _____

Caffeine Status: How many caffeinated drinks do you consume daily? _____

Language: English Spanish French Other _____

Race: White Black or African American American Indian

Other _____

Ethnicity: Hispanic or Latino Not Hispanic or Latino

Height: ____ft ____ in Weight: _____ lb.

Preferred Pharmacy and Pharmacy Address: _____

Signature_____ Date_____

RECEIPT OF NOTICE
OF PRIVACY PRACTICES

I have received a copy of **Adult & Pediatric Urology and Urogynocology, P.C.'s**
Notice of Privacy Practices that became effective April 14, 2003.

_____ _____
Date Print Patient Name

_____
Signature

Note: If signed by someone other than the patient, we need written proof of your authority.

I, _____, give my permission to Adult & Pediatric Urology, P.C., to give any & all medical information regarding myself to the following person(s):

_____

_____

_____

_____ _____
Signature Date

For office use: A signature was not obtained because: _____

_____

ADULT PEDIATRIC UROLOGY & UROGYNECOLOGY

It is the policy of Adult & Pediatric Urology and Urogynecology, P.C. to encourage our patients to arrive and receive care at their scheduled arrival time, or to give appropriate notice of cancellation to allow other patients to receive timely care.

If you are unable to make your scheduled appointment, we request that you notify us as soon as possible, but no later than 24 hours prior to your scheduled arrival time. Additionally, we request that you arrive at your scheduled arrival time.

By either not providing 24 hour notice of cancellation or choosing not to arrive without any notice to your scheduled appointment, **you will be charged a $100.00 fee for missed office visits in which an interpreter was scheduled.**

It is not our intent to assess an additional financial burden, but it is costly if you miss your appointment and do not give us adequate time to cancel the interpretation services that are provided for you.

If three (3) or more appointments are missed, Adult & Pediatric Urology and Urogynecology, P.C. reserves the right to terminate our relationship with you.

Patient Signature Date

Printed Patient Name Date

ADULT PEDIATRIC UROLOGY & UROGYNECOLOGY

10707 Pacific Street Omaha, NE 68114 Telephone: (402) 397-7989

FINANCIAL POLICY

We are extremely pleased that you have chosen Adult & Pediatric Urology, P.C. for your health care needs. This information regarding financial matters will be helpful to you in understanding our billing process. All patients must accept this FINANCIAL POLICY before receiving treatment.

1. Adult & Pediatric Urology, P.C. files insurance claims for patients as a courtesy. ***Regardless if you have an insurance plan, you still have full responsibility for payment of the bill.*** It is also the patient's responsibility to know if the physician he or she is seeing is a participating provider with his/her health plan.

2. **Co-payments** are always due at the time of service. Our contractual agreement with your carrier prevents us from waiving your required co-pay amount.

3. If you have **no insurance coverage, payment in full is due at the time of services.**

4. Payment for **elective or additional services** will be required at the time of service and will not be filed with your insurance company. This may include but is not limited to additional fees for copying of medical records or completion of FMLA/Short Term Disability paperwork.

5. We accept **CASH, MONEY ORDERS, CHECKS, VISA, MASTERCARD, CARE CREDIT and DISCOVER. You may also pay your bill online at: https://www.patientnotebook.com/AdultandPediatricUro/payment. You will also be enrolled to receive electronic statements if you provide our office with an email. If you do not wish to receive electronic statements, please contact our billing department.**

6. A **$40.00 service charge** will be assessed for returned checks.

7. **Pathology services** – if you have a biopsy taken, you may be billed separately for processing the slide and/or interpreting the slide. In some cases, a second opinion may be required to make a final diagnosis. Your insurance company may assess an additional co-payment for any lab or pathology services.

8. **Laboratory Services** – if you have blood drawn or urine cytology services, you may be billed separately by the laboratory that conducts the test(s). If your insurance company requires a specific laboratory for the processing of your blood work, it is your responsibility to notify the clinical staff at the time of the blood draw.

9. **If you cannot pay in full at time of service, please call** the business office at **(402) 399-7888** to make other arrangements. **Payments plans** are determined by the amount of the owed balance. The following guidelines will be followed:

* Balances up to $300 are to be paid in 3 monthly installments.
* Balances up to $600 are to be paid in 4 monthly installments
* Balances greater than $600 are to be paid in 6 monthly installments.

10. **Call to correct any billing errors promptly**. If you ignore our billing statements or telephone calls, we can only assume that you do not intend to pay for the medical services that were provided in good faith and your account will be forwarded to an outside collection agency.

11. **Referrals** – some insurance plans require that a referral from the primary care physician be obtained prior to be seen. It is the responsibility of the patient to obtain this referral. If a referral has not been obtained you may be responsible for a larger portion of your bill.

12. **Personal Injury** – we will not be a party to any litigation suits filed for personal injuries. We require payment in full and any payment from litigation is to be sought by you for reimbursement.

13. **Work Related Injuries** – pre-authorizations for care is the responsibility of the patient. If the prior authorization is not obtained, you are responsible for full payment at the time of service. If your workers compensation carrier has not paid your account within 45 days of the date of service, the owed balanced will become the responsibility of the patient.

I have read this policy and accept the terms as outlined above.

Signature: _____ Printed Name: _____ Date: _____