

WESTERN MICHIGAN UROLOGICAL ASSOC.

WELCOME TO OUR PRACTICE

Account # _____

Thank you for selecting our healthcare team. We are committed to providing you with the best possible care. Please fill out the form completely. If you need assistance, we will be happy to help.

Patient Information	Date _____
Name _____	Home Phone _____
Address _____	Cell Phone _____
City _____ State _____ Zip _____	Work Phone _____
Employer /School _____	Which number should we use as primary number? _____
Emergency Name _____	Birth Date _____ Age _____
Emergency Number _____	SS # _____
Sex: M / F Marital Status: S M D W	email address _____
Family Dr. _____	How did you hear about our office? referred, friend, yellow pages, other _____
Preferred Pharmacy _____ Address _____ Phone # _____	

If Patient Is Minor:

Father's Name _____	Mother's Name _____
DOB _____ SS# _____	DOB _____ SS# _____
Address _____ City _____ State _____ Zip _____	Address _____ City _____ State _____ Zip _____
Phone _____	Phone _____

Primary Insurance	Secondary Insurance
Insurance Company _____	Insurance Company _____
Cardholder's Name _____	Cardholder's Name _____
Relationship to Patient _____	Relationship to Patient _____
Cardholder's Birthdate _____	Cardholder's Birthdate _____
Social Security # _____	Social Security # _____
Home Phone # _____	Home Phone # _____
Cell Phone # _____	Cell Phone # _____
Work Phone # _____	Work Phone # _____
Employer _____	Employer _____
Group # _____	Group # _____
Contract _____	Contract _____
Effective Date _____/Copay \$ _____	Effective Date _____/Copay \$ _____

HIPAA Acknowledgment of Receipt

I have received a copy of the Notice of Privacy Practices (NPP).

Patient/Personal Representative Signature _____

Print Name / Relationship _____/_____

_____ Date _____

WESTERN MICHIGAN UROLOGICAL ASSOC.

Insurance

We will bill your insurance carrier as a courtesy to you, however payment for deductible and copay is due at the time of service. This includes all office visits, procedures, and injections. If you do not have your copay with you, your appointment may be rescheduled. Please remember... Your insurance coverage is a contract between you and your insurance company and **not** a substitute for payment.

We participate with Medicare, BCBS and many of the area employer plans. Please ask us if you are unsure whether we participate with your plan.

Referrals / Prior Authorizations

If your insurance has designated a primary care physician (PCP), you are required to have authorization from your PCP prior to your visit. If authorization is not provided, you will be asked to either reschedule your appointment or pay for your visit in full at the time of service. / **Prior Authorization:** Some insurances require prior authorization for procedures done in the office, this will be the patient's responsibility to check with their insurance prior to their visit to avoid possible higher deductible or copay charges.

Self-Pay Accounts / Plans We Don't Participate With

Self-pay accounts are patients that have no insurance coverage, have not met their deductible or are covered by insurance plans we do not participate with. Payment must be made at the time of service. If this is not possible, please discuss the situation with the billing department **before** your scheduled appointment.

On occasion a phone call from a physician or nurse for medical evaluation or symptom management might be requested by a patient. We offer that service for your convenience, however there may be a charge incurred for this service.

Payment Methods

For your convenience, we accept the following methods of payment: Cash, Personal Check, Visa, MasterCard, Discover.

Delinquent Accounts / No-Show Policy

In the event that your account should become delinquent, an outside collection agency may be utilized. / **No Show Policy:** If we do not receive a 24 hr. notice of a cancelled appointment, the **patient** will be charged at the time of the second (2nd) No-show/No-notification appointment.

Authorization and Release

I authorize payment of medical benefits be made directly to Western Michigan Urological Associates, PLC, HH Services Bates et al., LLC. I understand the financial policy and accept the personal responsibility for payment of covered and non-covered services. I authorize the release of any medical or other information necessary to process my claims.

Patient/Guardian Signature _____ Date _____

Medicare Information/Authorization

I request that payment of authorized Medicare benefits be made to Western Michigan Urological Associates, PLC, HH Services Bates et al., LLC. I authorize any holder of medical information about me, needed to determine those benefits or the benefits payable for related services, to be released to the Health Care Financing Administration or its agents. I also authorize Medicare to send Explanation of Medicare Benefits information to my Medicare supplement and benefits to be paid to Western Michigan Urological Associates, PLC, HH Services Bates et al., LLC, for any services furnished to me until further notice. I authorize any holder of information about me, needed to determine those benefits or the benefits payable for related services, to be released to the Health Care Financing Administration, or its agents.

Signature _____ Date _____



WESTERN MICHIGAN UROLOGICAL ASSOCIATES, PLC



577 Michigan Ave., Suite 201 Holland MI 49423 616-392-1816

Today's DATE: _____

NAME: _____ AGE: _____ BIRTHDATE: _____

OCCUPATION: _____ HEIGHT: _____ WEIGHT: _____

REASON FOR VISIT: _____

PAST MEDICAL HISTORY: please check all that apply to you

ALZHEIMER'S	LIVER DISEASE/HEPATITIS
ARTHRITIS	LUNG DISEASE
ASTHMA	MAJOR INJURY TYPE:
BACK PROBLEMS	MEASLES
BLOOD CLOTS	MIGRAINES
CARDIAC STENT	MUMPS
CHICKEN POX	NERVOUS BREAKDOWN
CLOT RETENTION	PACEMAKER/DEFIBRILLATOR
CONVULSIONS/SEIZURES	PARKINSON'S DISEASE
DIABETES	PNEUMONIA
CANCER TYPE:	POST OP HEMORRHAGE OR BLEEDING
DEPRESSION/ANXIETY	RHEUMATIC FEVER
GLAUCOMA	SCARLET FEVER
HEART ATTACK	SKIN DISEASE
HEARTBURN/GASTRIC REFLUX	STROKE
HEART TROUBLE	THYROID
HIGH BLOOD PRESSURE	TUBERCULOSIS
HIGH CHOLESTEROL/LIPIDS	ULCERS
HIV/AIDS	URINARY CATHETER
INFLAMMATORY BOWEL	URINARY TRACT INFECTION
IRREGULAR HEARTBEAT	VENEREAL DISEASE
JOINT REPLACEMENT TYPE:	WHOOPING COUGH
KIDNEY/BLADDER DISEASE	SERIOUS ILLNESS/OTHER TYPE:
KIDNEY STONES	

PLEASE LIST ALL PAST SURGERIES AND DATES AND ANY COMPLICATIONS

SURGERY	DATE	COMPLICATIONS

PLEASE LIST ALL MEDICATIONS YOU ARE TAKING AND DOSES

MEDICATION	DOSE

PLEASE LIST ANY ALLERGIES AND REACTIONS

ALLERGY	REACTION

PLEASE SELECT ANY OF THE FOLLWING THAT A **BLOOD** RELATIVE HAS HAD AND STATE WHICH RELATIVE IT WAS

DISEASE	FAMILY MEMBER
CANCER (TYPE)	
DIABETES	
HEART TROUBLE	
HIGH BLOOD PRESSURE	
KIDNEY TROUBLE	
MENTAL TROUBLE	
SEIZURES/CONVULSIONS	
STROKE	
TB (Tuberculosis)	

SOCIAL HISTORY:

DO YOU DRINK: YES NO HOW MUCH: _____ HOW OFTEN: _____

DO YOU SMOKE: YES NO HOW MUCH: _____ HOW OFTEN: _____

DO YOU USE ILLICIT/ILLEGAL DRUGS: YES NO HOW MUCH: _____ HOW OFTEN: _____

REVIEW OF SYSTEMS
Please mark any **CURRENT** issues

Constitution		Gastrointestinal
Fever		Heartburn
Chills		Nausea
Fatigue		Vomiting
Loss of appetite		Diarrhea
		Constipation
Eyes		Abdominal pain
Blurred vision		
Double vision		Integumentary
Eye pain		Skin rash
		Itching
HENT		New skin lesions
Sore throat		
Sinus pain		Neurological
Headaches		Tingling or numbness
		Memory difficulties
Cardiovascular		Tremors
Chest pain		
Lower extremity edema		Musculoskeletal
		Back pain
Respiratory		Joint pain
Shortness of breath		Muscle weakness or paralysis
Wheezing		
Cough		Hematological/Lymphatic
		Lymph node enlargement or tenderness
		Swollen glands
		Blood clotting problem

Western Michigan Urological Associates, PLC

Please complete the following information to enable us to contact you. It is important that we be able to contact you to provide laboratory and X-ray results, remind you of a future appointment, or re-schedule an existing appointment.

Patient Name: _____

Primary Contact Number: _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

I authorize the physicians and employees of Western Michigan Urological Associates, PLC, HH Services Bates et al., LLC to leave information regarding appointments, laboratory results, x-rays or other diagnostic tests at the above designated contact number/answering machine.

_____ YES

_____ **NO** – I understand by checking NO I cannot be contacted by phone about Up coming appointments, appointment reschedules and test results.

I authorize Western Michigan Urological Associates, PLC, HH Services Bates et al., LLC to communicate any and all aspects of my medical care, including but not limited to financial information with :

Name: _____ Relationship _____ Phone _____

Name: _____ Relationship _____ Phone _____

Name: _____ Relationship _____ Phone _____

_____ **I DO NOT authorize verbal information to be released to any individual.**

Signature of Patient/Guardian _____ Date _____