



# WESTERN MICHIGAN UROLOGICAL ASSOC.



577 Michigan Ave., Suite 201 Holland MI 49423 616-392-1816  
8300 Westpark Way Zeeland MI 49464  
www.westernmichiganurology.com

## PATIENT INFORMATION

(Please Print)

<b>APPT DATE/TIME:</b>	<b>APPT DR:</b>	<b>PCP:</b>	<b>ACCOUNT NO:</b>		
<b>DEMOGRAPHIC INFORMATION</b>					
<b>Last Name:</b>		<b>First Name:</b>		<b>Mi</b>	
<b>Address</b>			<b>Date Of Birth:</b>	<b>Age:</b>	<b>Sex:</b>
<b>City, State, Zip Code:</b>					
<b>Social Security #:</b>			<b>Marital Status:</b>		
<b>Home Phone:</b>			<b>Work Phone:</b>		
<b>Cell Phone:</b>			<b>Email:</b>		
<b>Preferred Pharmacy:</b>		<b>Address</b>		<b>Phone #:</b>	
<b>Race:</b> <input type="checkbox"/> American Indian <input type="checkbox"/> Asian <input type="checkbox"/> African American <input type="checkbox"/> Caucasian <input type="checkbox"/> Hispanic <input type="checkbox"/> Other <input type="checkbox"/> Do not wish to report			<b>Ethnicity:</b> <input type="checkbox"/> Hispanic <input type="checkbox"/> Non- Hispanic <input type="checkbox"/> Do not wish to report		
<b>Language:</b>					

<b>INSURANCE INFORMATION</b>		
(Please give your insurance card(s) to the person at the front desk)		
<b>Person Responsible for the Bill:</b>	<b>Address (if different from the patient):</b>	<b>Home Phone:</b>
<b>Is this person a patient here?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		

<b>Primary Insurance:</b>			<b>Employer:</b>	
<b>Subscriber's Name:</b>	<b>Subscriber's Date of Birth:</b>	<b>Policy Number:</b>	<b>Group Number:</b>	<b>Co-pay:</b>
<b>Patient's relationship to subscriber:</b>			<b>SS#</b>	

<b>Secondary Insurance:</b>			<b>Employer:</b>	
<b>Subscriber's Name:</b>	<b>Subscriber's Date of Birth:</b>	<b>Policy Number:</b>	<b>Group Number:</b>	<b>Co-pay:</b>
<b>Patient's relationship to subscriber:</b>			<b>SS#</b>	

<b>IN CASE OF EMERGENCY</b>		
<b>Name of Emergency Contact:</b>	<b>Relationship to Patient:</b>	<b>Contact Phone</b>

How did you hear about our office?  Doctor  Family/Friend  Health Seminar  
 Website  Yellow Pages  Other (Turn over to complete)

# WESTERN MICHIGAN UROLOGICAL ASSOC.

## Financial Policy

### 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.

### 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

In the event that your account should become delinquent, an outside collection agency may be utilized.

### No Show / Cancellation Policy

Please provide 24 hour notice if you are unable to keep a scheduled appointment. Failure to do so will result in a "No Show" fee upon the second occurrence. Payment of the fee will be required prior to the rescheduling of a new appointment. Multiple missed appointments may result in discharge from our practice.

## Authorization and Release

I authorize payment of medical benefits be made directly to Western Michigan Urological Assoc., 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 Assoc., 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 Assoc., 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 \_\_\_\_\_