West Georgia Urology

PATIENT MEDICAL HISTORY FORM
West Georgia Urology Associates, P.C.
150 Clinic Avenue, Suite 202
Carrollton, GA 301117
Phone:(770) 834-6988 Fax: (770) 834-1090

Today's Date: _____

Name:

_____
(Last) (First) (Middle Initial)

Date of Birth: ___/___/_____ Age: _____

Have you had any recent X-RAYS or SCANS? (CIRCLE ONE): YES or NO

Explain:_____

Reason for Visit:_____

When did symptoms start? _____ What makes them better?

_____

What makes them worse? _____Do you have fever or chills? _____

Circle the number that best describes the problem:

Not Bad – 1 2 3 4 5 6 7 8 9 10 – Very Bad

MEDICAL HISTORY:

Do you have or have you ever had any of the following: Circle Yes (Y) or No (N)

Heart disease	Y N	Who is your heart doctor? _____
Heart attack	Y N	When? _____
High Blood Pressure	Y N	
Diabetes	Y N	
Stroke	Y N	When? _____
Asthma	Y N	
Cancer	Y N	What kind? _____

		When? _____
Kidney Stone	Y N	When? _____
Urinary/Bladder Infection	Y N	How often? _____
Thyroid Disease	Y N	
Arthritis	Y N	
Glaucoma	Y N	

Other Medical Problems (please list):_____
_____

Previous Surgery: Circle Yes (Y) or No (N). If yes, indicate Date of Surgery.

Heart Bypass	Y N	When? _____	Hysterectomy	Y N	When? _____
Heart Angioplasty	Y N	When? _____	Tonsils	Y N	When? _____
Heart Stent	Y N	When? _____	Ear Tubes	Y N	When? _____
Gallbladder	Y N	When? _____	Bone or Joint	Y N	When? _____
Appendix	Y N	When? _____	Hernia	Y N	When? _____
C-section	Y N	When? _____			

Other Surgeries (please list):_____
_____

FAMILY HISTORY:

Father: Living? If yes, Age: ___ Deceased? Cause of Death: _____
Age at Death:___

Mother: Living? If yes, Age: ___ Deceased? Cause of Death: _____
Age at Death:___

Has any blood relative ever had any of the following? Circle Yes (Y) or No (N).

Heart Disease	Y N	Kidney Stones	Y N
High Blood Pressure	Y N	Prostate Cancer	Y N
Bleeding Disorder	Y N	Ulcers	Y N

Tuberculosis	Y N	Asthma	Y N
Hepatitis	Y N	Allergies	Y N
Diabetes	Y N	Stroke	Y N
Cancer	Y N		

SOCIAL HISTORY:

Chew/Dip Tobacco	Y N	How Long? ___ yrs. When quit? _____
Smoke	Y N	__Packs/day for ___ yrs. When quit? _____
Drink Alcohol	Y N	Amount? ____ for ___yrs. When quit? _____
Use Drugs	Y N	
Female Only: Menstrual Cycle	Y N	Date of last menstrual cycle _____

SYSTEM REVIEW:

Do you have or have you recently had any of the following? **Circle Yes (Y) or No (N).**

Constitutional		**Respiratory**		**Neurologic**	
Fever	Y N	Shortness of Breath	Y N	Tingling	Y N
Chills	Y N	Wheezing	Y N	Numbness	Y N

Eyes		**GI**		**Musculosketal**	
Blurry Vision	Y N	Nausea	Y N	Bone Pain	Y N
Double Vision	Y N	Vomiting	Y N	Joint Pain	Y N
		Constipation	Y N		

HENT		**Genitourinary**		**Endocrine**	
Sore Throat	Y N	Frequency	Y N	Night Sweats	Y N
Nasal Congestion	Y N	Voiding at Night	Y N	Weakness	Y N

Cardiovascular		**Integument/Skin**		**Psychiatric**	
Chest pain	Y N	Rash	Y N	Anxiety	Y N
Shortness of Breath with activity	Y N	Itching	Y N	Depression	Y N

West Georgia Urology Associates, P.C.

Patient Information **Today's Date: _____**

Full Name _____
(Last) (First) (Middle)

Birth Date _____ Age_____ Social Security No: _____

Sex: Male Female Marital Status: S M D W

Address _____
(Street)

_____ _____ _____ _____
(City) (State) (Zip) (County)

Home Phone_____ Work #_____ Cell #_____ Primary #_____

Employer _____Occupation_____
Address _____
Street City State Zip

Spouse or Guardian Information

Name _____ Relationship to Patient _____Birthdate_____
SSN_____ Employer _____
Employer Address _____
Street City State Zip

Insurance Information

Primary Insurance Co. _____

Name of Insured_____ Birthdate _____ Relationship_____

Secondary Insurance Co. _____

Name of Insured _____ Birthdate_____ Relationship _____

Additional Health Insurance: _____

Primary Care Physician: _____
Whom May We Thank For Referring You to Us? _____
In case of an Emergency, please contact: _____
Relationship:_____ Phone:_____ Alternate # _____

I authorize assignment and direct payment to **West Georgia Urology Associates, P.C.** any and all payments for medical and/or surgical services rendered to me. I understand that my insurance and/or Medicare may not cover all charges and that I am financially responsible for all charges that exceed or are not covered by my insurance and/or Medicare, including co-pays and deductibles and charges for non-covered services. I acknowledge that I am responsible for reasonable interest, collection fees, attorney fees and/or court costs incurred in connection with any attempt to collect amounts that I may owe to West Georgia Urology Associates, P.C.

SIGNATURE _____DATE _____

WEST GEORGIA UROLOGY ASSOCIATES, P.C.
Patient Financial Policy

It is the goal of West Georgia Urology Associates, P.C. ("WGUA") to provide quality medical care to our patients in an effective and pleasant manner. To avoid any confusion or misunderstanding, WGUA provides its patients with information related to your financial obligations and our financial policy and procedures. If you have any questions, please ask the receptionist to assist you.

Please read this document carefully, initial each item, sign and date where indicated.

___ WGUA files insurance claims as a courtesy and convenience to our patients. You, the patient, remain financially responsible for payment unless your insurer reimburses WGUA for the services pursuant to your insurance policy coverage. In order for WGUA to process your insurance claims, **you must present your current insurance card(s) and one form of photo identification with your current address to the receptionist at each visit in order for us to file a claim with your insurer on your behalf. Inability to provide your insurance and photographic identification documentation will result in your appointment being rescheduled or you will be required to pay all charges for the visit prior to being seen.** If you have more than one insurer, in order for the benefit coverage of your claim to be paid appropriately by your insurers, **you must produce proof of current insurance for each policy and you must indicate to the receptionist which insurance plan is primary and which is secondary**. If you have a change in your insurance company during the course of your treatment, it is your responsibility to timely provide the updated information to us to avoid your insurer's denial of coverage. Any updates of insurance information that are not timely received and result in the insurer's denial of your claims will be invoiced to you and must be paid prior to or at the time of your next appointment.

____ WGUA is obligated by insurance provider contracts to collect your co-pays and deductibles. **Co-pays and deductibles are collected at check-in before being seen by our providers.**

____ **It is your responsibility to verify your coverage with your insurer prior to your office visit**. In the event that your insurer determines a service is "Non-Covered," or "Not a Benefit," you, the patient, will be responsible for all charges.

____ It is your responsibility to obtain all necessary referrals and to follow your insurer's coverage plan guidelines and practices. **If a referral is required and our office does not receive this at the time of your appointment, we will be forced to reschedule your appointment.** Any discrepancies regarding the referral that are discovered may result in delay or rescheduling of your appointment. Patients may elect to self- pay in cases where discrepancies are discovered, if they so choose.

____ **If WGUA is not a participating physician provider for your insurer carrier, or if you have no insurance, payment in full will be required by you at the time services are rendered**. You may request that WGUA's Billing Department send a copy of bill to your insurer. This is done, upon your request, as a courtesy to you. No contractual adjustments to charges will be made by WGUA and payment in full will be required at time of service.

____ Any patient over the age of 18, or an emancipated minor, will be held financially responsible for all charges incurred. The parent(s) or legal guardian will be financially responsible for patients under the age of 18 years unless they are emancipated. WGUA does not involve its practice in the family or financial matters of its patients. If a court order or decree requires a party to be financially responsible for payment of healthcare services, that party must either be present at the time of service or make advance arrangements for payment.

____ In the event that after sixty (60) days from the date we file your claim your insurer has not reimbursed WGUA for services rendered or your insurer determines that the charges are the patient's responsibility, you will be mailed a detailed statement. These statements are sent monthly. **If you fail to meet your financial responsibility within sixty (60) days receipt of the statement, your account may be turned over to our collections agency. Patients are responsible for all collection fees, including attorney fees. All collection balances must be paid in full before future appointments can be made. For purposes of determining the date of receipt of the statement, you will be deemed to have received the statement three (3) business days after it is posted by the USPS to the current address you have given to WGUA. It is your responsibility to provide WGUA written notice of any changes to your address.**

___ **Worker's Compensation** – A Worker's Compensation authorization of payment form from your employer is required for all work-related visits and must be provided to WGUA upon check-in before being seen by our office. In order for WGUA to file a claim on your behalf for your worker's compensation healthcare benefits, we must receive your employer's authorization of payment. **You are financially liable for all services rendered to you if you fail to timely provide WGUA your employer's authorization of payment for worker's compensation benefits**.

___ **Surgical Prepayment Policy** – If your physician determines that surgery is needed, our office will consult with your insurance carrier and prepare an estimate of the charges for the proposed surgery. **West Georgia Urology Associates, P.C. requires that patients**

pay their portion of the surgical fees *in advance* of the procedure. Following many surgeries, there is a global period where no professional fee charges are made for follow-up visits. This grace period does not typically include the cost of supplies, labs, or other incidentals. Routinely, any costs that are billed to your insurance will also result in your insurer's determination that a charge for co-insurance is the financial responsibility of the patient. In that event, you will be billed for the co-insurance charges.

___ **Disability and Form Completion Policy** - In the event that you have need for Disability Insurance, FMLA or other forms to be filled out by our office, please be aware that although forms are completed as a courtesy to our patients, there is a **minimum charge of $25 per form payable in advance**. Completion of forms *usually* takes seven (7) to ten (10) *business* days for completion, to avoid unnecessary interruption to patient care. **No forms are completed on a rush or emergent basis so please plan accordingly**. If you are a Worker's Compensation patient, Work Comp does not reimburse for the completion of forms. **Forms received without payment will be returned to the patient uncompleted.**

____ **Appointment No Show/Late Cancellation Policy** – West Georgia Urology Associates, P.C. schedules appointments based on patient need and physician availability. **Patients need to arrive *30 minutes prior to appointment*, unless informed otherwise by the staff. You must notify our office at least 24 hours in advance if you will be unable to keep a scheduled appointment.** This allows other patients who may have an urgent need the chance to be seen in a timely fashion. Failure to provide timely notice of cancellation or failure to appear on time for your appointment, may result in a "No Show" charge for your appointment. The "No Show" charge for a missed appointment is $25 for a missed office visit and $50 for a missed procedure appointment. Repeat "No Shows" can result in the patient being dismissed from West Georgia Urology Associates, P.C. If you arrive 15 minutes or more late for your appointment, you are deemed a "No Show" for failure to arrive on time. Your appointment may have to be rescheduled to another date and time.

___ Patients are responsible for all costs related to delinquent accounts and a $30 fee will be assessed for any check returned for insufficient funds. At that time only cash, credit card or money order will be accepted for payment.

___ **Medical Records Requests**. In order to comply with HIPAA and Georgia law, and to minimize unnecessary and/or duplicative medical records requests which are costly and burdensome to WGUA, the following procedure and charges will be applied. **The cost of medical records is as follows**: $25.88 for search, retrieval and administrative costs; plus $9.70 for certification of the record (if requested), plus the actual cost of postage (if mailed); plus $0.97 for pages 1-20; $0.83 for pages 21-100; and $0.66 for every page over 100. **Upon receipt of your written HIPAA compliant request for medical records**, WGUA will notify you of the total cost based upon the actual charges to be incurred. When payment of these costs is received, WGUA will release or transmit your record, as directed in compliance with HIPAA and Georgia law.

___ As a patient you have the right to obtain your medical services from any provider. The physician owners of West Georgia Urology, PC want their patients to know that they have an ownership interest in Horizon Lithotripsy LLC, which provides lithotripsy services at Higgins General Hospital located at 101 Allen Memorial Drive, Bremen, Georgia.

____ **Assignment of Benefits**. I authorize assignment and direct payment to **West Georgia Urology Associates, P.C.** any and all payments for medical and/or surgical services rendered to me. I understand that my insurance and/or Medicare may not cover all charges and that I am financially responsible for all charges that exceed or are not covered by my insurance and/or Medicare, including co-pays and deductibles and charges for non-covered services. I acknowledge that I am responsible for reasonable interest, collection fees, attorney fees and/or court costs incurred in connection with any attempt to collect amounts that I may owe to West Georgia Urology Associates, P.C.

By signing below, I acknowledge that I have read and understand the financial terms of West Georgia Urology Associates, P.C.'s Patient Financial Policy. I agree to these terms and accept financial responsibility for all services rendered by WGUA to the patient.

_____ _____ _____

Signature of Patient or Responsible Party Please Print Patient Name Date

_____ _____

Print Name of Person Financially Responsible Relationship of Person to Patient

West Georgia Urology Associates, P.C.

Acknowledgement of Notice of Privacy Practices

Patient Name: _____ Date of Birth: _____

I understand that West Georgia Urology Associates, P.C. ("**WGUA**"), as my healthcare provider, is permitted to share my health information for treatment, payment and healthcare operations. I have been given a chance to review a current copy of WGUA's Notice of Privacy Practices describing how my health information will be used and shared by WGUA. I understand that WGUA has the right to change its Privacy Practices and that I may obtain a current copy by contacting the WGUA Privacy Officer at 770-834-6988. My signature below constitutes my acknowledgement that I have been given a chance to review a current copy of WGUA's Notice of Privacy Practices.

If a patient is physically unable to provide his/her signature OR signs with a mark, print his/her name on the appropriate line below and record the signature of two (2) responsible persons who witness that such person understands the nature of the WGUA Notice of Privacy Practices and the purpose of this acknowledgement. If patient is not capable of acknowledging the notice because of age or medical condition, complete the following:

Patient is a minor (_____ years of age)
Patient is unable to acknowledge because (state medical condition): _____

_____ _____
Patient/Legal Guardian/Relative Signature Date

_____
Legal Guardian/ Relative Relationship to Patient

_____ _____ _____ _____
Witness #1 Date Witness #2 Date

I understand the restrictions placed on WGUA by federal and state law regarding inability to share or discuss my medical information with others without my express written consent to do so. Therefore, **I request that WGUA discuss (initial one of the following):**
_____ <u>all aspects</u> of my medical condition, care and treatment OR
_____ <u>only the following aspects</u> of my medical condition, care and treatment: _____

_____
(PLEASE PRINT CLEARLY)
I request that WGUA discuss the above aspects of my medical condition with the person(s) listed below either: (a) in person only _____ **<u>OR</u> (b)** in person or on the telephone _____.
Initials Initials
I understand that I may revoke this consent upon a signed, dated written notice given to WGUA. _____
Initials

_____ _____
Person's Name Relationship to Patient

_____ _____
Person's Name Relationship to Patient

_____ Date: _____
Patient's Signature

Current Medications/ Allergy List

Date: _____

Patient Name: _____

Date of Birth: _____

Current Pharmacy: _____**Phone#**_____

Name of Medication	Strength (mgs)	Dosage (Times/Day)

Please list any medications you are allergic to