# Anne Arundel Urology, PA

**Account Number:** _____ **Provider:** _____

| Last Name | First Name | MI | | Birth Date | Age |
|---|---|---|---|---|---|
| Address | | | City | State | Zip Code |
| Home Phone | Work Phone | | Social Security # | Marital Status **M W S SP D** | Gender **M or F** |
| Cell Phone | Email Address (required for patient portal) **Do you want to receive billing statements via Email? Y N** | | | Employment Status FT PT RET UNEM | Student Yes No |
| Emergency Contact Information (Name/Phone Number/Relationship) | | | | Do you have an Advance Directive (Living Will)? Yes _____ No _____ | |

Is the physician listed below still your Primary Care Provider? **YES** _____ **NO** _____

**Physician:**

**Primary Care Physician:**

PLEASE COMPLETE THE FOLLOWING SECTION IF GUARANTOR IS DIFFERENT FROM PATIENT

| Last Name | First Name | MI | Relationship to Patient | |
|---|---|---|---|---|
| Address | | City | State | Zip Code |
| Home Phone | Work Phone | Social Security # | Birth Date | Gender |
| Cell Phone | Email Address | | | |

| PRIMARY INSURANCE | | SECONDARY INSURANCE | |
|---|---|---|---|
| Insurance Name | | Insurance Name | |
| Claims Address | | Claims Address | |
| City, State, Zip | Ins Phone No. | City, State, Zip | Ins Phone No. |
| Employer Group Ins? Yes ☐ No ☐<br>Employer Name:<br>Employer Address:<br>Employer Phone: | | Employer Group Ins? Yes ☐ No ☐<br>Employer Name:<br>Employer Address:<br>Employer Phone: | |
| Subscribers Name | Gender M ☐ F ☐ | Subscribers Name | Gender M ☐ F ☐ |
| Subscribers ID | Group No. | Subscribers ID | Group No. |
| Subscribers Birth Date & SSN | Effective Date | Subscribers Birth Date & SSN | Effective Date |
| Patient's Relation to Subscriber: Self ☐ Spouse ☐ Child ☐ Other ☐ | | Patient's Relation to Subscriber: Self ☐ Spouse ☐ Child ☐ Other ☐ | |

**AUTHORIZATION**

Our primary responsibility is to help our patients experience good health. Payment for services is expected to be paid at the time of service, including co-payments. If you do not pay your co-pay on the date of service, your appointment may need to be rescheduled.
Our billing office will submit all claims to your insurance carrier. Any outstanding balances are due at the time of first billing.
I authorize the release of medical records or other information necessary to process my claims, as well as payment of medical benefits to Anne Arundel Urology, P.A./Anne Arundel Urological Surgery Center, LLC. I also acknowledge that I am responsible for any missed appointment or cancellation fees incurred.

I, _____, fully understand that I am responsible for payment of services rendered.

Patient Signature _____ Date _____

# PATIENT HIPAA COMMUNICATION FORM

**PATIENT NAME:**_____ **BIRTH DATE:**_____ **ACCT. #:**_____

**PRIVACY NOTICE TO PATIENTS**

By signing below, I acknowledge that I have been provided the opportunity to review the Notice of Privacy Practices that is posted in each clinic location and on the practice website. I understand that a copy of the Privacy Practices will be printed for me at my request.

_____

Patient or Legal Guardian Signature Date

**CONFIDENTIAL COMMUNICATION OF PERSONAL HEALTH INFORMATION**

It is the policy of AA Urology not to release confidential medical information regarding your treatment to family members or friends without written permission. Please indicate below, who you would like to give access to your personal and confidential personal health information. This includes: picking up prescriptions in office, medical records, referrals, instructions for outside testing, voicemail messages, etc.

| Name | Relationship | Phone Number |
|---|---|---|
| Name | Relationship | Phone Number |
| Name | Relationship | Phone Number |
| Name | Relationship | Phone Number |

***If you do not wish to have your confidential medical information released to anyone other than your insurance, please check the box:*** ☐

_____

Patient or Legal Guardian Signature Date

The information contained in this medical record document is considered private and confidential patient information. This information can only be used for the medical diagnosis and/or medical services that are being provided by the patient's selected caregivers. This information can only be distributed outside of the patient's care if the patient agrees and signs waivers of authorization for this information to be sent to an outside source or route.

# FINANCIAL POLICY

**PATIENT NAME:**_____ **BIRTH DATE:**_____ **ACCT. #:**_____

We are committed to meeting your healthcare needs and keeping your insurance and other financial arrangements as simple as possible. In order to accomplish this, we ask that you adhere to our practice's financial policy. By signing below, you are agreeing to its terms.

1. I am ultimately responsible for payment of all charges for services I receive from this practice, including those covered by my insurance. As a convenience, this practice will submit claims for reimbursement with my insurance provider; however, all payment responsibility is ultimately mine.

2. Some immediate payment may be expected at the time of service. This may include a co-pay, a previous balance, or an additional payment if this practice determines that the cost of my visit today will not be reimbursed by my insurance provider. This often happens if my deductible is not yet satisfied.

3. **All co-pays are due at the time of service. This practice may deny service for failure to pay a co-pay at my scheduled visit.**

4. It is my responsibility to provide my current address, telephone number, email address, insurance card(s) and referral, if required, at each visit.

5. If warranted, this practice may offer the option of paying my share of costs via an automated payment plan. I understand that my payment is due by the date shown on my statement. I also understand that failure to pay could result in my account being sent to an outside collection agency.

6. I understand that I have the *option* of maintaining my preferred payment method on file. I understand that by completing the below section and providing my Card or ACH information, my payment information will be maintained on file digitally for future use by the practice for patient balances due. The applicable payment card or ACH information will be truncated and "tokenized" by the payment agent in order to help maintain the security of my payment information. Card or ACH Information will be obtained through a card swipe, manual entry from card, void check, or orally in person or over the phone.

   *Optional:* ☐ Keep my preferred payment method on file for future use

   _____
   Name as it Appears on Card/ACH Account

7. With my prior approval, I authorize the above practice and/or its designated pmt agent to apply charges to my payment card and/or ACH account, using my preferred payment method stored on file, for balances I owe to the practice. This could be for medical visits, procedures, amounts agreed as part of a payment plan, copayments, coinsurance, amounts not covered by insurance or fees (if applicable) charged by the practice for failure to keep an appointment or provide timely notice of appointment cancellation.

8. In the case of a patient balance that is not satisfied by a charge to my payment method or a payment plan, I may receive a monthly statement for any outstanding balance. I am responsible for paying this balance by its due date in order to avoid my account being sent to an outside collection agency.

9. Transaction receipts will be provided to me in person if paying on site, mailed if requested, or will be emailed to me if I provide and maintain a valid email address.

This authorization will remain in effect until I provide written notice of cancellation to the practice. Authorization for services already rendered cannot be cancelled or refunded. I agree to notify the practice in writing of any changes in my payment or other information.

AUTHORIZED SIGNATURE _____ DATE _____

Billing Address City State Zip Code

Anne Arundel
UROLOGY

Patient Name: _____

DOB: _____

Referring Physician: _____ Primary Care Physician: _____

Pharmacy Name: _____ Pharmacy Location: _____

The following information is confidential and will not be released to anyone without your authorization.

CHIEF COMPLAINT (What is the main reason for seeing the doctor?):

_____

List any other MEDICAL PROBLEMS, including the use of a CPAP machine

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

No Changes since last year check here _____

Number of pregnancies _____ Number of deliveries _____

List all SURGERIES you have had, including heart valve or joint replacement (include month/year if possible)

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

No Changes since last year check here _____

List all MEDICATIONS you take including dosage and frequency (please include Aspirin if taken daily):

1. _____ 6. _____
2. _____ 7. _____
3. _____ 8. _____
4. _____ 9. _____
5. _____ 10. _____

**Do you take antibiotics prior to a dental visit Yes _____ No_____

Please list any ALLERGIES to medications or latex. Please list their names and the reaction (i.e. – rash, hives, etc.):

_____ _____

_____ _____

FAMILY HISTORY

***Have any members of your family had or have Diabetes, Heart Disease, Respiratory issues, Stroke, or any type of cancer? If yes, please specify:

_____

SOCIAL HISTORY

Marital Status: Single _____ Married _____ Widowed _____ Separated _____ Divorced _____

Occupation _____

Do you currently smoke cigarettes/cigars/pipe? NO _____ YES _____ If so, how much?_____

Did you ever smoke? NO _____ YES _____ If so, when did you quit and how much?_____

Do you drink alcohol? NO _____ YES _____ How much?_____

REVIEW OF SYSTEMS No changes since last year check here _____

Do you have any problems related to the following systems? (Please circle)

**GENERAL**
Change in energy
Weight gain
Chills
Fever
Change in mobility

**SKIN**
Itching
Rash
Ulcers
Lesions

**HEAD, EYES, EARS, NOSE, & THROAT**
Double Vision
Head Injury/Trauma
Visual Loss
Hearing Loss
Ringing in Ears
Nasal Congestion
Hoarseness

**RESPIRATORY**
Chronic cough
Shortness of Breath
Wheezing
Bloody Sputum
Recent Respiratory Infection
Hay fever
Environmental allergies
Chronic Immune Problems

**HEART**
Chest pain
Shortness of Breath with Exercise
Palpitations

**GASTROINTESTINAL**
Abdominal Pain
Tarry stools
Blood in Stool
Constipation
Diarrhea
Nausea
Vomiting
Bloating

**URINARY**
Burning with Urination
Frequency
Urinary leakage
Waking up to void
Urgency
Unable to void

**MUSCULOSKELETAL**
Back pain
Decreased range of motion
Joint pain
Joint swelling

**NEUROLOGIC**
Trouble Walking
Memory loss
Difficulty speaking
Stroke
Seizures

**PSYCHIATRIC**
Anxiety
Depression
Mood changes

**ENDOCRINE**
Appetite change
Cold intolerance
Excessive thirst
Heat intolerance
Thyroid problems

**HEMATOLOGY**
Prolonged Bleeding
Anemia
Easy bruising

# ANNE ARUNDEL UROLOGY

## Out of Network Insurance Waiver Form

Our Staff Member has identified that you need to sign a waiver for today's visit. Please read through this form and sign and date where indicated in the appropriate section.

PATIENT NAME: _____ DOB: _____ A/C NUMBER: _____

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### MEDICARE ADVANTAGE PLANS

*** We are not directly contracted with most Medicare Advantage Plans. If you are insured by a Medicare Advantage Plan and no longer have traditional Medicare, your insurance may not cover our services. Please sign the waiver below.*

I acknowledge that I have been informed that you are not directly contracted with my insurance carrier and, therefore, my insurance may not honor my visit today. I understand that you will submit a one-time claim on my behalf, but I am agreeing to assume **ALL** financial responsibility. This agreement pertains to todays and all future visits with this insurance carrier.

Insurance Company _____

Signature _____ Date

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### OUT OF STATE BCBS PLANS

*** We are only contracted with BCBS of Maryland. We are not directly contracted with Bluecard plans outside the state of Maryland. If you are insured by a BCBS plan outside the state of Maryland, your insurance may not cover our services. Please sign the waiver below.*

I acknowledge that I have been informed that you are not directly contracted with my insurance carrier and, therefore, my insurance may not honor my visit today. I understand that you will submit a one-time claim on my behalf, but I am agreeing to assume **ALL** financial responsibility. This agreement pertains to todays and all future visits with this insurance carrier.

Insurance Company _____

Signature _____ Date

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