MICHIGAN UROLOGICAL CLINIC – 4047 EAST HILLS CT SE – GRAND RAPIDS, MI 49546

PLEASE BRING COMPLETED FORMS WITH YOU TO YOUR APPOINTMENT

** indicate required fields

**Today's date_____

**Name_____ **Date of birth_____

**Address_____ **City_____ **State_____ ** Zip_____

**Phone_____(home) _____(mobile)

**Email:_____ **Social Security #_____

**If patient is a minor: Responsible party name_____ Date of birth_____

Address_____ Phone_____

**Preferred Pharmacy _____

Pharmacy location and phone number_____

Are you employed? _____ Place of employment?_____

What is the chief problem that brings you here?_____

How long has the problem occurred?_____

MEDICATIONS: please list medications you have recently been taking:

1._____ 2._____

3._____ 4._____

5._____ 6._____

7._____ 8._____

9. _____ 10._____

ALLERGIES: please indicate any allergies to medications and other substances

_____

_____

IMAGING STUDIES: please indicate any recent imaging studies, approximate date and location obtained

_____

_____

_____

SOCIAL HISTORY:

Tobacco use?_____ If no have you ever smoked?_____

Alcohol? (amount per week)_____ caffeinated beverages amount per day_____

Recreational drug use?_____ Special diet?_____

HISTORY OF BLOOD RELATIVES (please circle all that apply)

Alcoholism Migraines Diabetes Epilepsy Nervous Breakdown

Kidney Stones Kidney Failure Kidney Cancer Testicular Cancer

Glaucoma Stroke Breast Cancer Colon Cancer

High Blood Pressure Tuberculosis Bladder Cancer Prostate Cancer

Other cancer (please list)_____

Please circle any of the following symptoms you are experiencing:

Fever Chills Weight loss

Blurry Vision Double Vision Cataracts

Hearing loss Nasal Stuffiness Sore Throat

Chest Pain Swollen Ankles Irregular Heartbeat Previous Heart attack

Shortness of Breath Wheezing Chronic Cough

Abdominal Pain Nausea/Vomiting Change in Bowels

Incontinence Painful Urination Blood in Urine

Chronic Back Pain Chronic Neck Pain Sore Muscles

Rash Persistent Itching Skin Cancer History

Numbness Tingling Dizziness Previous CVA/TIA/Stroke

Swollen Glands Abnormal Bleeding Transfusion History

Seasonal Allergies Previous Subdural Hematoma High Blood Pressure

Michigan Urological Clinic 4047 East Hills Ct S.E. Grand Rapids, MI 49546 616-956-9577

NEW PATIENTS:

Please arrive 15 minutes early for your first appointment with your completed new patient forms if they were not returned prior to your appointment. Please bring a photo id and all insurance cards, along with the names of current medications and medical history. In most cases you will also be asked to supply us with a urine specimen upon arrival for your appointment.

Any recent X-rays or imaging studies pertaining to your appointment should be brought with you to your appointment.

RESCHEDULING APPOINTMENTS:

If you are unable to keep your appointment, please call our office as soon as possible so that we may reschedule your visit. Please provide at least 24-hour notice.

CONTACT INFO:

Our office is open 8:00 am – 4:00 pm and office phones are answered from 8:30 am to 4:00 pm. Calls over the lunch hour and after hours are routed to our answering service. A healthcare provider is on-call at all times to help with urgent problems.

PRESCRIPTION REFILLS

If you require a refill between appointments, please call during regular office hours, Monday through Friday. Medications will not be refilled evenings or weekends except in emergencies.

Patient Acknowledgement

I hereby acknowledge that I have been offered a copy of MICHIGAN UROLOGICAL CLINIC P.C's Notice of Privacy Practices.

★Patient Name (printed) _____★ Date of birth_____

Voicemail Permission

YES: _____I DO authorize the physicians and staff of Michigan Urological Clinic to leave a voicemail message regarding my care including (but not limited to), scheduled appointments, lab and x-ray reports.

NO: ____ I DO NOT authorize the physicians and staff at Michigan Urological Clinic to leave a voicemail message regarding my care.

Release of Information

I hereby grant permission to Michigan Urological Clinic, P.C. to release my protected health information to the following family members and/or friends who may be involved in my care: Please print clearly

__Spouse (Name)_____ _____

__Other (Name/Relation)_____

__Other(Name /Relation)_____

MICHIGAN UROLOGICAL CLINIC FINANCIAL POLICY

1. Insurance. We participate with most insurance companies and will submit charges directly to your insurance company. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. Non-Participation with Insurance: If we do not participate with your insurance, we will still submit charges directly to your insurance and most insurance companies will pay for out of network services. Patients will be responsible for the remaining balance. Please contact your insurance company to determine out of network charges and your financial responsibility.

3. **Narrow networks** – Some insurances offer "narrow networks" and will only pay for services when their members see a specialist that participates within that narrow network.

4. Co-payments and deductibles. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Please help us in upholding your contract by paying your co-payment at each visit.

5. Non-covered services. Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

6. Proof of insurance. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the updated and correct insurance information in a timely manner, you may be responsible for the balance of a claim.

7. Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

8. Nonpayment. If your account is over 90 days past due, you will be expected to pay your account in full prior to your next appointment. If payment arrangements have been made for a past due balance, and you continue to pay monthly as agreed, we will continue your medical care. In addition to making payments on past due balances, **current office charges (co-pays, co-insurance or deductibles) must be paid in full at the time of the appointment.**

9. Payments: We accept the following forms of payments: Cash, Personal check or Money Orders, Visa, MasterCard, Discover, American Express and Debit cards. **(Exception: Personal checks are NOT accepted for Vasovasostomy procedures. Forms of payment accepted for this procedure are cash, cashier check, credit or debit cards.)**

Please be aware that if a balance remains unpaid we may refer your account to a collection agency and you may be discharged from this practice. If this is to occur, you will be notified by certified mail that you have 30 days to find alternative medical care. During that 30-day period, care will be provided on an emergency basis only. Please let us know if you have any questions or concerns regarding our financial policy.

I have read and understand the payment policy and agree to abide by its guidelines:

_____ _____

Patient printed name **Signature of patient or responsible party**

Date _____