Urology Associates of Silicon Valley

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Financial Policy

Welcome to our office. Thank you for choosing us as your urologist. The following is a statement of our Financial Policy which must be read and signed prior to any treatment. We hope this helps answer any questions you have regarding our billing policies.

Insurance:

Our office contracts with most insurance companies. Your insurance company provides you with proof of insurance that must be presented for all services. We bill all primary insurance plans for our patients. Payment for co-payments deductibles. and payment for any non-covered service is required at your visit. If you have no insurance, your account is considered a cash account and payment in full is due at the time of service. For your convenience we accept check, cash, Visa and MasterCard.

Your individual insurance plan is an agreement between you and your insurance company. It is necessary for you to know the specific details of your plan. If your plan requires a referral for specialty services, it is especially important to notify us if there are restrictions on referrals to outside facilities for services. You will be liable for all charges from those outside providers if they are not contracted with your plan and you have not received the proper pre-authorization. It is your responsibility to know if your referral has expired and to obtain a new referral.

Patient Information:

You will be asked to fill out a patient information form at your initial visit and each year thereafter. In order to keep our file up to date, please inform us of any changes to your information such as insurance, address, telephone number, medical history and medications

Missed appointments: Please cancel your appointment 24 hours in advance to avoid being charged. Please help us serve you better by keeping scheduled appointments.

After Hours Services: All non-emergency services rendered after regular business hours are subject to an additional fee. Our regular business hours are Monday through Friday, 9:00 AM -5:00 PM excluding Holidays.

I have read, understand and agree to the Financial Policy.

Signature _____date _____

Please print name _____

2581 Samaritan Dr. Suite 200 San Jose, CA 95124 408-358-2030 fax 408-3582036

PATIENT INFORMATION: (Mr. Mrs. Ms.) DATE: _____

Last Name: _____ First Name._____ MI___ AGE_____

Address: _____ City _____

e-mail (optional)_____ Cell Phone_____

Birth date _____ Phone _____ Sex_____ Soc Sec_____

Name of Employer _____Phone_____ Ext_____

Spouse _____ Birth date _____

Name of Employer _____ Phone_____

If Minor-Name of Mother and Father_____

Mother's Place of Employment _____ Phone _____

Father's Place of Employment _____ Phone _____

Name of your Primary Care Doctor_____

INSURANCE INFORMATION

Does your insurance require authorization for office visits?_____

Primary Insurance:_____ Effective:

Address: _____ City _____State_____Zip_____

ID#_____ Group _____ Co Pay _____

Name of Policy Holder _____ Relationship _____Birth date_____

2ND Insurance:_____Effective _____

Address: _____ City _____ State_____ Zip_____

ID#_____ Group _____ Co Pay _____

Name of Policy Holder _____ Relationship _____Birth date _____

OVER

To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize release of patient information.

I hereby assign all medical and/or surgical benefits, including major medical benefits to which I am entitled. This assignment shall remain in effect until revoked by me in writing. A photocopy of this assignment shall be considered as a valid an original. I understand that I am responsible for all charges for services rendered. Any amount unpaid by my insurance, such as deductible, co-payment or balance not covered, is my responsibility.

If this account is assigned to an attorney or collection agency, the prevailing party shall be entitled to attorney's fee, collection fee's and related costs. All accounts 90 days past due may be subject to service charge of 1.5% per month (18%APR).

SIGNED (responsible party) Date

MEDICARE EXTENDED AUTHORIZATION
"SIGNATURE ON FILE"

NAME (please print) MEDICARE #

I request that payment of Medicare benefits be made either to me or to my doctor at Urology Associates of Silicon Valley for services rendered to me for one year from the date of this form. I authorize the release of information, as necessary to satisfy submitted claims, by the above named medical office to Medicare.

PATIENTS SIGNATURE DATE

YOUR MEDICAL HISTORY

NAME_____DATE OF BIRTH _____

Height _____ Weight _____

ALLERGIES TO MEDICATIONS

OTHER ALLERGIES

MEDICATIONS YOU ARE NOW TAKING (INCLUDE DOSAGE)

LIST PAST SERIOUS ILLNESS AND SURGERIES (INCLUDE DATES)

Have you ever had any problem with anesthesia? Yes _____No
If yes what was the reaction?_____
Do you bleed easily or have a known bleeding disorder? Yes_____No
Have you had a prior blood transfusion? Yes_____No _____

NAME OF PHARMACY _____ NUMBER

Name of Doctor of friend that referred you to our office _____

WHY ARE WE SEEING YOU TODAY?

CHECK YES OR NO

HEAD AND NECK

GLASSES OR CONTACTS	YES	NO
MIGRAINE	YES	NO
DIZZINESS	YES	NO
FAINTING	YES	NO
SEIZURES	YES	NO
CONCUSSION	YES	NO
DEAFNESS	YES	NO
RINGING IN EARS	YES	NO
DOUBLE, BLURRED OR LOSS OF VISION	YES	NO
TEMPORARY CROWNS	YES	NO
IRREGULAR OR UNUSUAL SNORING	YES	NO
ACTIVE COLD SORES	YES	NO
GUM DISEASE	YES	NO
DENTURES	YES	NO
SLEEP APNEA	YES	NO

CHEST AND HEART

COUGH	YES	NO
TUBERCULOSIS	YES	NO
PNEUMONIA	YES	**NO**
SHORTNESS OF BREATH	YES	**NO**
HEART MURMUR	YES	NO
CHEST PAIN	YES	NO
HEART ATTACK	YES	NO
RHEUMATIC FEVER	YES	NO
HIGH BLOOD PRESSURE	YES	NO
HEART DISEASE	YES	NO
ARTERY DISEASE -	YES	NO
IRREGULAR HEART	' YES	NO
ASTHMA	YES	NO
COPD (EMPHYSEMA)	YES	NO

BREAST

SKIN CHANGES	YES	NO
PAIN	YES	NO
NIPPLE DISCHARGE	YES	NO
LUMPS	YES	NO

DO YOU HAVE A [r] OF CANCER? Yes No IF YES , WHERE?
HISTORY

ARE YOU HIV POSTTVE? Yes No

GENITAL / URINARY

KIDNEY STONES	YES	NO
KIDNEY DISEASE	YES	NO
FREQUENT URINATION	YES	NO
PAINFUL URINATION	YES	NO
LOSS OF CONTROL	YES	NO
DISCHARGE FROM PENIS	YES	NO
GENITAL HERPES	YES	NO
HIGH RISK SEXUAL ACTIVITY	YES	NO
PROSTATE PROBLEM	YES	NO

NERURO MUSCULAR

ARTHRITIS	YES	NO
GOUT	YES	NO
BACK PAIN	YES	NO
SHOOTING PAIN IN ARMS OR LEGS	YES	NO
MUSCLE WEAKNESS	YES	NO
STROKE	YES	NO

GYNECOLOGIC (WOMEN ONLY)

KNOWN GYN ILLNESS	YES	NO
VAGINAL DISCHARGE	YES	NO
HIGH RISK SEXUAL ACTIVITY	YES	NO
GENITAL HERPES	YES	**NO**
POST MENOPAUSAL BLEEDING	YES	NO
NUMBER OF PREGNANCIES	YES	NO
LAST MENSTRUAL PERIOD	YES	NO
NUMBER OF ABORTIONS	YES	NO

ENDOCRINE

DIABETES	YES	NO
THYROID DISORDER	YES	NO
ADRENAL DISEASE	YES	NO

ABDOMEN

LIVER DISEASE	YES	NO
ULCER OR STOMACH PROBLEMS	YES	NO
HEPATITIS	YES	NO
GALLBLADDER DISEASE	YES	NO
INFLAMMATORY BOWEL DISEASE	YES	NO
HERNIA	YES	NO
CHANGE IN STOOLS	YES	NO
BLOOD IN STOOLS	YES	NO

Do you have any other health problems or concerns?

FAMTLY HISTORY

	AGE	LIVING	WELL	ILLNESS	CAUSE OF DEATH
MOTHER					
FATHER					
SISTERS 1.					
2..					
BROTHERS l.					
2.					

SOCIAL HISTORY

Do you smoke?: Yes_____No ____ How many packs per day? _____How many years?

Have you smoked regularly in the past? Yes _____No How many years?_____

How much liquor per day? _____

Any history of IV or recreational drugs:? Yes _____ No_

For office use only

_____

_____

Date_____

Physician

10-01-99

Acknowledgement of Receipt of Notice of Privacy Practices

Urology Associates Of Silicon Valley
2581 Samaritan Drive #200
San Jose, CA 95124
408-358-2030

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

Signed: _____ Date:

Print Name: _____ Telephone: _____

If not signed by the patient, please indicate:

Relationship:

- □ parent or guardian of minor patient
- □ guardian or conservator of an incompetent patient
- □ beneficiary or personal representative of deceased patient

Name of Patient: _____