Cancellation and No-Show Policy

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, North Dallas Urology-McKinney reserves the right to charge the following No Show and Cancellation Fees:

• No Show of a New Patient	$100.00
• No Show of an In Office Procedure	$75.00
• No Show of an Established Patient	$50.00
• No Show of a Facility Procedure	$100.00

"No Show" fees will be billed to the patient. This fee is not covered by insurance and must be paid prior to your next appointment. Multiple "No Shows" in any 12-month period may result in termination from our practice.

INSURANCE & PAYMENT COLLECTION POLICY

It is the patient's responsibility to provide our office with the most recent insurance coverage information. All Co-Pays, Deductibles & Co-Insurances will be collected at check-in **every time** a service is provided by our office. For medical procedures, you will be notified with the estimated amount that we obtain from your insurance company. Your responsibility amount will be due the day of the procedure. Once the claim has been processed by your insurance, it is considered final and any adjustments to your account will be made if needed.

Thank you for your understanding and cooperation as we strive to best serve the needs of our patients.

By signing below, you acknowledge that you have received this notice and understand this policy.

________________________________ Date ________________________
Printed Name

____
Signature

NORTH DALLAS UROLOGY ASSOCIATES

5300 W. Plano Parkway, Suite 200
Plano, Texas 75093
972-612-8037 ♦ 972-612-4414 (fax)

4501 Medical Center Drive, Suite 100
McKinney, Texas 75093
972-548-8195 ♦ 972-543-1985 (fax)

FINANCIAL RESPONSIBILITY AGREEMENT

I, ________________________, understand that I am responsible for all charges incurred for my medical treatment. I consent to those medical benefits from my insurance policy are paid directly to North Dallas Urology Associates, in consideration of services rendered up to the total amount of my account.

Any balance remaining after insurance benefits have been paid is my responsibility. I will pay the balance within 60 days unless other arrangements have been made. I understand that in the event of default, my account will be sent to a collection agency.

It is my responsibility to provide the correct insurance information (claims address, phone numbers, ID numbers, etc.). I will pay any balances resulting from inaccurate insurance information.

NORTH DALLAS UROLOGY will file claims with my primary and secondary insurance companies ONLY. If I have a third insurance company, I will file those claims myself. I understand that I am responsible for all remaining balances after my second insurance company has paid.

Every possible effort will be made to obtain payment for my claims. I agree to pay my account balance in the event the insurance company(ies) do not respond.

ALL COPAYS AND DEDUCTIBLES ARE DUE AT TIME OF SERVICE. I also agree to pay for in-office labs/x-rays/tests at the time of service as outlined by my insurance company.

There is a $45.00 fee for disability forms that need to be completed prior to surgery or any form requiring dictation by the doctor, and a $25.00 fee for a copy of your medical records.

It is my responsibility to obtain all referrals and to verify the in-network status of my doctor. If I do not have a proper referral, my appointment will be rescheduled until one is obtained.

I authorize the release of medical records necessary to process insurance claims.

Signature: ____ **Date:** ____________________

NORTH DALLAS UROLOGY-McKinney

4501 Medical Center Dr, Ste 100, McKinney, TX 75069

www.northdallasurology.com

KIDNEY STONE QUESTIONNAIRE

Name______________________________ Date of birth______________ Date________________

How many times have you passed stones on your own?___ What year? _____ _____ _____

Have you had surgery for stones? Shock wave? What year? _____ _____ ____ _____

Camera and laser(ureteroscopy)? What year? ___________ _______________ _______________

Stent? What year? ________________ ________________ ________________

Who in your family has kidney stones? (e.g. mother, brother, son) _______ _______ _______

Do you have (circle all that apply):

Extra belly weight

Diabetes

Recurrent urinary tract infections Gout

Intestine removed

Hyperthyroidism

Sarcoidosis

Crohn's disease

Ulcerative colitis

Pancreatitis

Celiac disease

Weight loss surgery

Unusual kidney shape or location (e.g. horseshoe kidney, history kidney blockage, pelvic kidney)

Do you take (circle all that apply):

calcium supplements

vitamin C

vitamin D

topiramate (Topamax)

zonisamide (Zonegran)

triampterene (Maxide, Dyazide, Dyrenium)

probenecid (Probalan) for gout

lipase inhibitors for weight loss (orlistat or Alli, Xenical)

chemotherapy

protease inhibitors for HIV (indinavir or Crixivan, atazanavir or Reyataz)

Does your diet include (circle all that apply):

Low fluids

Low fruit and vegetable intake

Lots of meat or protein from animal sources

Lots of salt/sodium

Too much or too little calcium

Morgan MSC and Pearle MS. Medical management of kidney stones. American Urological Association Update Lesson 20, Volume 34. American Urological Association Education and Research, Inc. Linthicum, MD, 2015.

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up care among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payors.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of *Notice of Privacy Practices*.
I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

Patient Name: ____**Date:** _____________________________

Signature of patient (or Authorized Representative): ____

Relationship to Patient: ____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement of this *Notice of Privacy Practices Acknowledgement,* but was unable to do so as documented below:

DATE: ___________________________**INITIALS:** ________________ **REASON:** _______________________

Signature: ____

McKinney Office: William C. Mitchell, M.D. ♦ Jared D. Stringer, M.D. ♦ Jeremy M. West, M.D.

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Date: ______________________
(Fecha)

First Name: ____________________ **Last Name:** ____________________ **MI:** _______
(Nombre) *(Apellido)* *(Inicial)*

Address: ____

Apt/Suite: ____
(Direccion)

City: State: ________________________ **Zip:** __________ *(Ciudad) (Estado) (Codigo Postal)*

Phones: Cell _______________ **Work** _______________ **Home** _______________
(Tel. Celular) *(Tel. de Trabajo)* *(Tel. de Casa)*

Social Security #: ____________________ **Date of Birth:** ______________________
(# Seguro Social) *(Fecha de Nacimiento)*

Patient Marital Status: S / M / D / W **Patient Sex: Male / Female** **Employed: Yes / No / Ret / Dis**
(Estado Matrimonial) *(Sexo del Paciente)* *(Empleado)*

For reporting purposes only:

Primary Language Spoken: ____________ **Ethnicity:** ____________ **Race:** __________
(Lenguage Principal) *(Ednicidad)* *(Raza)*

E-Mail: ____________________________________

Appointment Reminder Preference: **Mail** *(Correo)* **Phone** *(Telefono)* *E-Mail(Preferencia de Recordatorio de Cita)*
Please circle above.

<u>INSURANCE INFORMATION</u>:

Primary Insurance *(Seguro Primario)* ____

Name of Policy Owner: ______________________ **DOB:** __________ **Relation:** _______
(Nombre del dueño de la Poliza *(Fecha de Nacimiento)* *(Relacion)*

Secondary Insurance *(Seguro Secundario)*: ______________________________________

Name of Policy Owner: ______________________ **DOB:** __________ **Relation:** ________
(Nombre del dueño de la Poliza *(Fecha de Nacimiento)* *(Relacion)*

Do you reside in an ASSISTED LIVING or a NURSING FACILITY? Yes / No
(¿Recide usted en un lugar de ASISTENCIA DE VIVIENDA o ASILO DE ANCIANOS? (Si / No)

If yes, please fill out the following information:
(Si la respuesta fue Si, porfavor de llenar la siguiente informacion)

Name of Facility *(Nombre de la Facilidad)*: ________________________________
Address *(Direccion)*: **Phone** *(Telefono)*:

Have you ever seen one of our doctors before? YES / NO, If Yes, whom: ____________
(¿Ha visto usted alguno de nuestros doctores anteriormente?) *(Si / No, ¿A quien?)*

In case of emergency notify: _________________ **Phone:** ________ **Relation:** ________
(En caso de emergencia notifiacar a) *(Telefono)* *(Relacion)*

Primary Care Physician: __________________________ **Referred by:** ______________
(Doctor Principal) *(Doctor que Refirio)*

How did you hear about us? ____
(¿Como escucho de nosotros?)

NORTH DALLAS UROLOGY ASSOCIATES-MCKINNEY

PAYMENT POLICY

Upon contact with our business office, we will request your insurance information. We are required by many insurance companies to get pre-certification numbers and benefits. This protects you as well as us from having unexpected out-of-pocket expenses. Our staff will call your insurance company to verify your benefits and also check on your current deductible, co-payment, and coinsurance. This information will be shared with you. In order to control our billing costs, we request the deductible, co-payment, and/or coinsurance be paid as they relate to the charges at the time of service. Payment may be made by cash, check, MasterCard, Visa, Discover, or American Express.

MEDICARE PATIENTS

If your primary insurance is Medicare, then we will file the claim for you. We do accept Medicare assignment which means we will bill you only what Medicare allows. Medicare will pay 80% of the allowable, minus any deductibles, and you will be responsible for the other 20% allowable plus any remaining deductible. If you have a secondary insurance policy, we will file that for you as a courtesy. Some secondary insurance policies reimburse directly to the patient and/or insured. If your insurance company does this, please forward the payment to us in the form of cash, check, or credit card.
Note: At times, there may be a procedure or test done in-office that is required to be sent out to a lab or pathologist. In these cases, you may be billed by a third party for these services.

LABS

We, out of courtesy collect your specimen and send it to our preferred lab for processing and analysis of results. We do not have the capability to provide this service in our office, therefore if you do not wish to have your specimen collected or sent to our preferred laboratory please specify prior to services. We use the following laboratories: LabCorp, Bostwick & Dr. Lamm, Pathologist

MANAGED CARE PATIENTS

We request you pay your co-payment at the initial onset of your visit. If your deductible has not been met for the year, you will also need to pay any unmet deductible for the services rendered. After your deductible has been met, you will then be responsible for only your co-payment and/or coinsurance. Any procedure done may be subject to an additional surgical deductible depending on your insurance plan. We will file all claims for the services rendered by the physician.
Assignment of insurance benefits, deductible, co-payments, and/or coinsurance are required before elective surgery. We will try to fulfill all insurance requirements for pre-certification; however, we cannot be responsible for a reduction in benefits if this is not done. Therefore, we encourage you to contact your insurance company before any surgical procedures are done.

Note: At times, there may be a procedure or test done in-office that is required to be sent out to a lab or pathologist. In these cases, you may be billed by a third party for these services.

Please be advised that we request a minimum of 24-hour cancellation notice prior to your scheduled appointment. Please see Cancellation and No-Show Fee Policy for additional information.

Assignment of Benefits

I authorize the release of medical records to determine liability for payment and to obtain reimbursement. I assign all medical and/or surgical benefits including Medicare, private insurance, and other health plans to my physician. This assignment will remain in effect until revoked by me in writing. I understand I am financially responsible for all charges incurred by myself and/or my dependent.

Signed: ____ **Date:** ____________________
Parent or guardian if patient is a minor: ____

Physician Disclosure

To further our commitment to the quality of medical and surgical care for our patients, we have chosen to be an owner in the entities listed below.

Our ownership enhances our ability to direct the manner in which your care is delivered at the facility. If this of concern to you, the Physicians' will be happy to answer any questions.

We are on the medical staff at other healthcare facilities and will be happy to discuss your option of choosing an alternative location.

McKinney Surgery Center
Baylor Medical Center at Frisco
North Dallas Radiation Oncology Center
Methodist McKinney Hospital
US Lithotripsy

ACKNOWLEDGEMENT: (I / We) have read this "Notice to Patients" form, and (I / We) understand the disclosures that it contains.

Date this ____________ Day of __________________, 20___

____
Signature of Patient or Guardian

North Dallas Urology Associates
4501 Medical Center Drive, Suite 100
McKinney, Texas 75069
Tel: 972-548-8195●Fax: 972-543-1985

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PATIENT AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Date: ___________________

Patient Name: ____

Date Of Birth:____

Description of the specific information to be used or disclosed: (Please check one of the following:)

☐ **All information**

Or Specific information like the following (Please list below)

- ✓ ☐ **pick up patient's medical records**
- ✓ ☐ **cancel, reschedule, make appointments for patient**
- ✓ ☐ **call to get patient's results**
- ✓ ☐ **pick up patient's medicine/samples**

Write names of people we can give out information to and the relationship to them.
If you *DO NOT* want us to release any information to anybody, just cross out the page.

Name: ______________________ Relationship: __________ Phone: ____________________

Name: ______________________ Relationship: __________ Phone: ____________________

Name: ______________________ Relationship: __________ Phone: ____________________

Name: ______________________ Relationship: __________ Phone: ____________________

Name: ______________________ Relationship: __________ Phone: ____________________

- I understand that:
- I may inspect or copy the protected health information to be used or disclosed.
- I may revoke this authorization in writing by contacting your office at the address above, attention Privacy Officer.
- Information used or disclosed pursuant to the Authorization may be subject to re disclosure by the recipient and no longer be protected by HIPAA.

Patient Signature: ____________________________ **Date** ____________________________

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NAME: _______________________________ DOB___________ DATE: _______________

CHANGES IN PRESCRIPTIONS or Over the Counter Drugs

DRUG NAME	MG (DOSAGE)	TIMES A DAY	# PER DAY

What symptoms are you having today?

- ◻ Fever
- ◻ Chills
- ◻ Headaches
- ◻ Blurred Vision
- ◻ Pain
- ◻ Sore Throat
- ◻ Sinus Pain
- ◻ Mouth Ulcers
- ◻ Runny Nose
- ◻ Tremor
- ◻ Dizziness
- ◻ Tingling/numbness
- ◻ Too Hot/Cold
- ◻ Tired/Sluggish
- ◻ Loss of Libido
- ◻ Shortness of Breath
- ◻ Chest Pain
- ◻ Varicose Veins
- ◻ High Blood Pressure
- ◻ Swelling of ankles
- ◻ Joint Pain
- ◻ Neck Pain
- ◻ Back Pain
- ◻ Urinary Incontinence
- ◻ Pain with Urination
- ◻ Urinary Urgency
- ◻ Urinary Frequency
- ◻ Urinary Retention
- ◻ Pain with Intercourse
- ◻ Erectile Dysfunction
- ◻ Wheezing
- ◻ Anxiety
- ◻ Nausea
- ◻ Blood Clotting Problem
- ◻ Abdominal Pain
- ◻ Boils
- ◻ Seasonal Allergies
- ◻ Swollen Glands
- ◻ Heartburn
- ◻ Vomiting
- ◻ Diarrhea
- ◻ Constipation
- ◻ Depression
- ◻ Double Vision
- ◻ Rash
- ◻ Itching

Urology Health History Questionnaire:

DATE OF BIRTH______________________________

NAME____

Address____

Local phone number________________________________ Alternative phone number___________________

Please describe what problem or concern brought you to our office today:

☐ Primarily to establish care ☐ Other (please briefly describe)____

Special Communication Needs:			
Language preference:			If 'yes' to any of the questions below, how can we assist?
Visual impairment	☐ Yes	☐ No	
Hearing impairment	☐ Yes	☐ No	
Speech impairment	☐ Yes	☐ No	
Cognitive impairment	☐ Yes	☐ No	
Sensory impairment	☐ Yes	☐ No	

Personal Health History		Previous Surgical Procedures	
Please check past(P) or current(C) problems or conditions		Please check if you have had any of the following	
		Procedure	Year
P☐ C☐ Anxiety	P☐ C☐ Bladder problems		
P☐ C☐ Blood disorder	P☐ C☐ Heart condition	☐ Breast surgery	
P☐ C☐ High blood pressure	P☐ C☐ Liver problems	☐ Hysterectomy	
P☐ C☐ Hepatitis	P☐ C☐ Neurological condition	☐ Vascular surgery/stent	
P☐ C☐ Psychiatric condition	P☐ C☐ Depression	☐ Spine surgery ☐ Neck ☐ Back	
P☐ C☐ Thyroid disorder	P☐ C☐ Lung disorder	☐ Heart surgery	
P☐ C☐ Diabetes	P☐ C☐ **Cancer**	☐ Prostate surgery	
P☐ C☐ Breast problems	Type: ______________________	☐ Other:	
P☐ C☐ Kidney problems	P☐ C☐ Sexually transmitted disease	________________________________	
P☐ C☐ Abnormal pap smears	P☐ C☐ Other:_________________	________________________________	
P☐ C☐ Stomach problems	☐ No current medical conditions	________________________________	

Urology Health History

Frequency of urination: Daytime___________________ Nighttime __________________

Strength of Stream: Normal: __________________ Decreased: __________________ Poor: ________________

Blood in Urine:	☐ Yes ☐ No		Leakage of Urine:	☐ Yes ☐ No	
Urinary Infections:	☐ Yes ☐ No		Interruption of Urinary Stream:	☐ Yes ☐ No	
Kidney or Bladder Stones:	☐ Yes ☐ No		Split Stream:	☐ Yes ☐ No	
Urgent Urination:	☐ Yes ☐ No		Burning/Discomfort with Urination:	☐ Yes ☐ No	
Dribbling After Voiding:	☐ Yes ☐ No		Hesitancy in Initiating Stream:	☐ Yes ☐ No	

Social History:

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Life Partner **In a sexual relationship?** ☐ Yes ☐ No

Live here year round? ☐ Yes ☐ No If no, Part time location: ____

Occupation: **Concerns:** ☐ Stress ☐ Hazardous subst. ☐ Heavy lifting **Exercise:** ☐ No ☐ Yes: _
________________________________times/week

Tobacco use: ☐ Never ☐ Quit (when)_____________ ☐ Current smoker: Packs/day, how many years________________________

Alcohol use: ☐ No ☐ Yes If yes how many drinks/how often_________________

Caffeine use: ☐ No ☐ Yes If yes, ☐ Coffee ☐ Soda ☐ Tea how many drinks/how often_________________

Illicit Drug use (including marijuana, cocaine, steroids): ☐ Never ☐ Past ☐ Current
Describe:____

Family History

Specifically, have any of your relatives had the following conditions:

Condition	Relative	Condition	Relative
☐ Mental illness		☐ Chemical dependency	
☐ Diabetes		☐ Stroke	
☐ Thyroid Disease		☐ Arthritis	
☐ Pituitary Disease		☐ Dementia	
☐ Chrohn's/Colitis		☐ Cancer: ☐ ______________	
☐ Heart Disease < 65 years of age		(List types) ☐ ______________	
☐ Hypertension		☐ ______________	

Are there any religious or cultural factors that you would like us to take into account when planning your healthcare?

Health Maintenance:

Please check whether you have had the following preventive services and enter the year of the service

Immunizations	Last Occurrence	Tests	Last Occurrence
Influenza vaccine ☐ Yes ☐ No		Mammogram ☐ Yes ☐ No	
Gardasil (HPV) vaccine rec'd ☐ Yes ☐ No		Pap smear/pelvic ☐ Yes ☐ No	
		Colonoscopy ☐ Yes ☐ No	
		Bone Density ☐ Yes ☐ No	

Hospital Admissions (excluding pregnancies):

Date	Hospital	Reason for admission

ALLERGIES: Please list *any* allergies to medications, foods, or materials (including latex)

Name	Symptom/Reaction

Pharmacy: ______________________________ **Phone**: ____________________ **Store #**: ____________________

Location Description: ____

Additional Providers:

Primary Care Provider	**Other:** ______________________
Name: ______________________________	Name: ______________________________
Phone: ____________________ Last Seen: __________	Phone: ____________________ Last Seen: __________

Patient/Guardian Signature: ____ Date: ____________________