NEW YORK UROLOGICAL ASSOCIATES, P.C.

212-570-6800

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Date: _____ ***HOW DID YOU HEAR ABOUT US? (_)www.nyurological.com (_)WEB SEARCH (_)REFERRING MD (_)HOSPITAL REFERRAL (_)FRIEND/FAMILY (_)INSURANCE (_)OTHER*** _____

Last name: _____ First name: _____MI._____

Address: _____ Apt: _____

City: _____ State: _____ Zip code: _____

Home #: _____ Mobile: _____ Email:_____

Office #: _____ Date of birth: _____ /_____/_____ Sex: _____ Age: _____

Social Security#: _____- _____ - _____ Emergency contact: _____ Phone#_____

Occupation: _____ Employer: _____

Marital status: _____ Spouse name:_____

Mother's 1st Name: _____ Father's 1st Name: _____

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- **Primary Care Physician's name:**_____email:_____
- Primary Care Contact info: _____
- **Referring Doctor's name:**_____email:_____
- Referring Doctor's Contact info:_____

***Reports should go to?**:_____email:_____

Address, city & state: _____ Phone: _____Fax#:_____

- **Pharmacy Information:** _____

Please provide Name, Phone number, address and Fax~~ * ~~

Allergies: _____

Medications (Current):_____

INSURANCE SECTION-BY LAW, ALL INSURANCE INFORMATION MUST BE DISCLOSED

What is your AGE TODAY_____ **[**Are you on MEDICARE? __ Yes __ No**][**Are you on Disability __Yes __No**]**

- Primary Insurance _____ Member ID# _____Group#_____
- Policy Holder's Name_____ _____Relationship: _____ Date of birth: _____
- 2. Secondary Insurance:_____ Member ID# _____ Group#_____
- Policy Holder's Name_____ _____ Relationship: _____ Date of birth: _____
- 3. Tertiary Insurance:_____ Member ID# _____ Group#_____
- Policy Holder's Name_____ _____ Relationship: _____ Date of birth: _____

Additional insurance information can be written in the back Thanks!

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Financial Policy

ALL FORMS MUST BE COMPLETED AND SIGNED BEFORE SEEING A DOCTOR

*****MEDICAID:** I understand that the practice is not part of the Medicaid program. As such I agree to pay for all fees incurred in my medical care provided by NEW YORK UROLOGICAL ASSOCIATES, PC or any of their doctors.

*****PRIVATE INSURANCE:** Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Therefore, YOU ARE RESPONSIBLE FOR FULL PAYMENT AT THE TIME OF VISIT

*****PARTICIPATING INSURANCE:** All co-payments and deductibles are payable at the time of visit. Your signature below authorizes payments to us for our services. You are responsible for obtaining a referral number. If you do not, you are required to pay at the time of visit as an "out of network." If your insurance does not cover a special procedure and you would like it performed anyway, you are required to sign an acknowledgement and pay at the time of service. This waives your right to submit it to your carrier for denial.

*****MEDICARE INSURANCE**: We accept assignment. We will electronically submit your claim. Medicare will mail an Explanation of Benefits to you. You can then submit this to your co-insurance. I request that payment of authorized Medicare benefits be made to me or on my behalf to NY UROLOGICAL for services furnished to me. I authorized any holder of medical information about me to be released to the healthcare financing administration agents any benefits for related services.

******MEDICARE BENEFICIARY NOTICE******

Medicare will only pay for services that it determines to be "reasonable and necessary" under 1872(a) (1) of Medicare law. I have been notified on the date indicated that ***Medicare is likely to deny payment for test/treatment if I exceeded the prescribed frequency for either the prescribed test/treatment***. I agree to be personally responsible for payment if Medicare denies payment.

******RELEASE OF INFORMATION******

I hereby authorize NY UROLOGICAL to release to insurance carriers or others who are, or may be financially responsible for my medical care, all information needed to substantiate payment for my medical care. I have read the above and agree to this policy as stated.

******CREDIT CARD/DEBIT CARD ON FILE******

To make collecting CO-INSURANCE and DEDUCTIBLES after your claims have been processed more efficient we ask for a valid Credit Card to be on file. A Credit Card form will be furnished.

******COMMON FEES******

Please note: We make every effort to accommodate our patients and arrange for your visit and or procedure requirements in advance. We also make every effort to collect balances for your services in a timely fashion.

- **A $50.00 Fee will be invoiced to all late Appointment Cancellations/NO SHOWS. All appointment CANCELLATION must be made with at least business 24 hours** prior notice.
- **A $200.00 Fee will be invoiced to all late Surgery Cancellations. All surgery CANCELLATIONS must be made with at least 72 business hours** prior notice.
- **A $5.00 Late Payment Fee will be added to all accounts with balance older than 60 days from the first invoice. This fee will be added every month the account is unpaid.**
- **A $10.00 processing fee plus 75 cents per page will be charged for ALL Copy of Records not related to referrals. Records will be furnished by fax (if fewer than 30 pages), by mail or pick-upon CD as a pdf document.**

Patient Name_____ **Signature**_____Date_____

245 East 54th Street #2N, New York, NY 10022
Phone: 212-570-6800
Fax: 212-734-7425 and 212-861-7964
www.nyurological.com

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212-570-6800

November 15, 2017

CREDIT/DEBIT CARD ON FILE POLICY

To Our Patients:

We have implemented a convenient payment policy using a credit card to be held on file effective January 1st, 2018. As you may be aware, the current healthcare market has resulted in insurance plans increasingly transferring costs to you, the patient. Many insurance plans require deductibles, coinsurance and/or copays in amounts that are unknown to you, or to us, at the time of your visit. Our patients will be asked for a credit card at the time of check in. Your card information will be held securely until your insurances have paid their portion and notified us of the amount you owe. Any remaining balance owed by you will be charged to your card on file and a receipt will be emailed to you at the email address provided by you.

A valid credit card, debit card, HSA or FSA card will be accepted.
Cards on File will be used for:

- Copays – When you come into the office, we will ask you if you want to use your card on file to pay your copay for today's visit. You may choose to present another card if preferred, or any other form of payment accepted by our office.
- Deductibles – Your card on file will be utilized to settle any deductible amount due after your insurance plan has paid their portion for your visit or service. It is always a good idea to contact your insurance plan to determine how much of your annual deductible has been met, prior to each visit.
- Co-Insurance – Your card on file will be utilized to pay for your percentage not covered by insurance and not paid at the time of your visit or service. For example: If your insurance covers at 80% we will require the 20% balance be paid after your insurance has paid their portion.
- Outstanding Balances – If your account has a previous outstanding balance, your card on file may be used to settle that outstanding balance. If the outstanding balance is too large for one transaction, a payment plan may be worked out.

The Financial Policy has been amended and includes an "Credit Card on File" This is just another form of collecting that payment. Nothing is changing about how much you pay. When you come to our office and receive a service, you do so with the understanding that you are ultimately responsible for the cost of your care.

This notice is available on our website, emailed to our patients prior to each appointment and presented to our patients at check-in. See the attached Frequently Asked Questions for more information.

Thank you for your understanding and cooperation.

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Date: _____

ACKNOWLEDGMENT AND CONSENT HIPPA

By signing below, I acknowledge that I have read the Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by the physician private practice listed at the beginning of this notice, and how I may obtain access to and control this information. I also acknowledge and understand that I may request copies of separate notices explaining special privacy protections that apply to HIV/AIDS related information, alcohol and substance abuse treatment information, mental health information, and generic information, finally, by signing below, I consent to the use and disclosure of my health information to treat me and arrange for my medical care, to seek and receive payment for services given to me, and for the business operations of this practice, its physicians, and staff.

_____

1. Signature of Patient OR Patient's authorized Representative

_____

2. Print Name of Patient OR authorized Representative