Methodist Urology Associates

Methodist Urology Associates
The Methodist Hospital Physician Organization

18400 Katy Freeway
Suite 350
Houston, TX 77094
P. 832-522-8300
F. 832-522-8301

Dear Patient,

Thank you for choosing our office. We understand and appreciate the confidence this choice represents at Methodist Urology Associates; we strive to provide state-of-the-art urologic services in a caring and comfortable environment. To assist us in providing the best service possible, we request the following:

- Arrive 15 minutes prior to your scheduled appointment time. Please bring your insurance card and valid ID.

- Some insurance companies require a referral/ authorization to see a specialist. If yours does, you must obtain a referral and/or authorization from your primary care provider in time for your scheduled appointment. If you do not obtain a referral and/or authorization, your appointment may be rescheduled.

- We try to obtain your medical record prior to scheduling your appointment. If we are unable to do so, we request you bring all pertinent medical records, prior x-ray films, and any diagnostic test results.

- Your co-payment and/or deductible are due at the time of service. If you are unable to pay your co-payment and/or deductible, your appointment will be rescheduled. We accept cash, check and most major credit cards, American Express, Discover and Visa/MasterCard.

- A scheduled appointment means that this time is reserved only for you. We request that if you cannot make your appointment that you give us 24 hours advanced notice. As a courtesy, we will remind you of your appointment the day before it is scheduled.

Please complete the enclosed patient registration forms. The completed forms can also be mailed in or faxed to (832) 522- 8301 prior to your appointment.

If you have any questions, please feel free to call our office at (832) 522-8300.

Sincerely,

The Staff of Methodist Urology Associates- West Houston

Methodist Urology Associates
Financial Acknowledgement

Billing Office (713) 441-0577 Fax: (713) 790-5866

We are committed to providing you the best possible care. In order to better serve you, please read and familiarize yourself with our financial policies so that misunderstandings regarding our billing can be avoided. If you have any questions, please do not hesitate to call or email our billing office.

- **You are in-network / out-of-network with our physician. If you would like a copy of the benefits we verified please ask the receptionist.**

- **If you are on an insurance plan that requires a referral, it is your responsibility to obtain that referral from your primary care physician and bring it with you to your visit. If no referral is obtained, you may be financially responsible for the costs of your visit in its entirety.**

- **Methodist Urology Associates no longer files insurance claims to insurance companies with which it does not have a contractual relationship. If we are out-of-network with your insurance, you will be required to pay in full at the time of service and submit a claim to your insurance company. If your physician is out of network with your insurance your payment (which may range from $100 to $500) is due at time of service.**

- **At your request, we will provide an estimate of today's services. If you are requesting an estimate of charges for future services it may result in a delay in scheduling and provision of the services. Estimates will be provided no later than 10 business days after the request is made. We have 10 business days after the date on which the estimate was requested.**

- **We have a returned check fee of $35.00 that will be assessed on all checks not paid by your bank for any reason.**

- **We will provide you an itemized statement of all services preformed. If you request more than two copies of the statement, our office may charge a reasonable fee for the third statement and subsequent copies provided. The Texas Board shall, by rule, set the permissible fee a physician may charge for copying, process, and delivering a copy of the statement**

- **At any time if you do not understand your statement we shall provide, in plain language, a written explanation of the charges for services or supplies previously made on a bill or statement.**

- **It is the policy of the Practice to monitor and manage appointment no-shows. A patient who fails to arrive for a scheduled appointment without canceling the appointment less than 24 hours prior to the scheduled time is considered a "no show". The charge for a no-show patient is $25, as set by the Practice. You will be billed this amount and it will be reflected on your statement.**

- **We will refund you within 30 days after the date the facility determines an overpayment has been made. Therefore, if you are aware of any overpayment please feel free to contact our billing office.**

Print Patient Name_____

Signature of Acknowledging Party_____ **Date**_____

MEDICARE SECONDARY PAYER QUESTIONAIRE

1. Are you receiving Black Lung benefits (BL) and the service being performed is covered by BL? Yes No

2. Has the Department of Veterans Affairs (DVA) authorized and agreed to pay for these services at this facility? Yes No

3. Are these services to be paid by a government research grant? Yes No

4. Was the illness/injury due to a work related accident/condition that is covered by WC? Yes No

5. Was the illness/injury due to a non work related accident? Yes No
   If yes, is another party responsible?
   (Circle one and give insurance information to front desk)
   A. No insurance available
   B. No-fault insurance is available
   C. Liability insurance is available

6. Are you receiving Medicare based on : (circle one)
   A. Age
   B. Disability
   C. End-stage Renal Disease

7. If **AGE**, are you currently: (circle one)
   A. Employed
   B. Retired
   C. Never worked

8. If **AGE**, is your spouse currently: (circle one)
   A. Employed
   B. Retired
   C. Never worked

9. If you or your spouse **is employed**, are you receiving Group Health Plan coverage? Yes No

10. Does the employer that sponsors your Group Health Plan **employ 20 or more employees**? Yes No

Signature of patient: _____ Date: _____

Methodist The Methodist Hospital
Physician Organization

May 1, 2011

TMH PHYSICIAN ORGANIZATION AND ITS PHYSICIANS
NOTICE OF PRIVACY PRACTICES

This notice describes how information about you may be used and disclosed and how you can get access to this information.
Please review it carefully.

This Notice of Privacy Practices identifies the general ways your protected health information can be used or disclosed. Protected health information is the individually identifiable personal health information found in your medical and billing records. This information is created or received by a health care provider, insurance company, or employer, and relates to your past, present, or future physical or mental health conditions or the payment for health care services. This information can be transmitted or maintained in any form by TMH Physician Organization and its Physicians.

This Notice describes your legal rights regarding your health information. It also informs you of the legal duties and privacy practices of TMH Physician Organization and its Physicians with respect to health information created for services generated in the individual offices of each physician of TMH Physician Organization. If you receive services by your physician or a health care provider at a different location, there may be different health information privacy policies or notices, and there will be different contact information.

For the purpose of this Notice, the terms "TMH Physician Organization and its Physicians," "TMH Physician Organization," "we" and "our" refer to TMH Physician Organization as an organization as well as each individual physician affiliated with the TMH Physician Organization, with respect to health information generated or maintained by TMH Physician Organization's physicians.

OUR LEGAL DUTIES

We are required, by law, to keep your identifiable health information private; provide you with this Notice of our legal duties and privacy practices with respect to your health information; and follow the terms of the Notice as long as it is in effect. If we revise this Notice, we will follow the terms of the revised Notice, as long as it is in effect.

HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION

The following information describes how we are permitted, or required by law, to use and disclose your health information. Not every use or disclosure in a category will be listed.

Treatment: We may use or disclose your health information to a physician or other health care provider in order to provide care and treatment to you. For example, a physician treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. We also may disclose health information about you to those who may be involved in your health care outside of TMH Physician Organization, such as hospitals, physicians, and others who provide you with follow-up care and medical equipment or product suppliers. We may contact you to provide appointment reminders and to provide you with information about health-related benefits and services provided by TMH Physician Organization or by The Methodist Hospital System, or treatment alternatives that may be of interest to you.

Payment: We may use or disclose your health information to obtain payment for services we provide to you. We may disclose your health information to another health care provider or entity. For example, we may need to provide your health plan with information about surgery you received so your health plan will pay TMH Physician Organization or reimburse you for the surgery. TMH Physician Organization also will tell your health plan about a treatment you are going to receive to obtain the health plan's prior approval for this treatment or to determine whether your plan will cover the treatment.

Health Care Operations: We may use or disclose health information about you to support the programs and activities of TMH Physician Organization and The Methodist Hospital System such as quality and service improvement; health care delivery review; staff performance evaluation; competence or qualification review of health care professionals; education and training of physicians and other health care providers; and business planning and development, business management and general administrative activities. We use this information to continuously improve the quality of care for all patients we serve. For example, we may combine health information about many patients to evaluate the need for new services or treatments. We may disclose information to doctors, nurses, and other students for educational purposes. And we may combine health information we have with that of other facilities to see where we can make improvements.

Additionally, we may share your health information with other health care providers and payors for certain of their business operations if the information is related to a relationship the provider or payor currently has or previously had with you, and if the provider or payor is required by federal law to protect the privacy of your health information.

Health Information Exchange: We may make your health information available electronically through an information exchange service to other providers involved in your care who request your electronic health information. Participation in information exchange services also lets us see their information about you. The purpose of this information exchange is to support the delivery of quality patient care.

Authorization for Other Disclosures: We will not use or disclose your health information, except as described in this document, unless you authorize us, in writing, to do so. You can revoke an authorization at any time, in writing. If you revoke an authorization, we will no longer use or disclose your health information for the purpose covered by the authorization. However, we are unable to take back any uses or disclosures already made with your authorization. Specific examples of uses or disclosures requiring authorization include: use of psychotherapy notes, marketing activities, the sale of your health information and most uses and disclosures for which we are compensated.

Family and Friends: We may use or disclose information to notify or assist in notifying a family member, personal representative, or other person responsible for your care, of your location and general condition. We will also disclose health information to a family member, other relative, close personal friend, or any other person you identify, if the information is relevant to that person's involvement with your care or payment for your care. You can prohibit disclosure of this information.

Fundraising: We may use or disclose health information about you to contact you in an effort to raise money for our organization and its operations. We may disclose this information to The Methodist Hospital Foundation to assist us in our fundraising activities. Only contact information such as your name, address and telephone number, and the dates you received treatment or services at TMH Physician Organization would be released. You have the right to opt out of fundraising communications at any time and your request must be honored. Any such communication will have clear and conspicuous instructions on how to opt out of future communications.

Future Communications: We may use or disclose your information to communicate with you via newsletters, mailings or other means regarding treatment options, health related information, disease-management programs, wellness programs, or other community based initiatives or activities in which TMH Physician Organization participates. If we receive any financial compensation for such communications, we will inform you. You have the right to opt out of receiving such compensated communications at any time and we must honor your request. Any such communication will have clear and conspicuous instructions on how to opt out of future communications.

Public Health and Safety: We may use or disclose health information, as authorized or required by local, state or federal law, for the following purposes deemed to be in the public interest or benefit:

- To report certain diseases and wounds, births and deaths, and suspected cases of abuse, neglect, or domestic violence;
- To help identify, locate, or report criminal suspects, crime victims, suspicious deaths, or criminal conduct on the premises of TMH Physician Organization's physicians;
- To respond to a court order, subpoena, or other judicial process;
- To assist federal disaster relief efforts;
- To enable product recalls, repairs, or replacements;
- To respond to an audit, inspection, or investigation by a health-related government agency;
- To assist in federal intelligence, counterintelligence, and national security issues;
- To facilitate organ and tissue donations;
- To assist coroners, medical examiners, and funeral directors;
- To respond to a request from a jail or prison regarding an inmate's health or medical treatment;
- To respond to a request from your military command authority (if you are a member or veteran of the armed forces);
- To provide information to a workers' compensation program.

Business Associates: There are some services provided at TMH Physician Organization and its Physicians through contracts with business associates. When these services are contracted, we will disclose your health information to the business associate so they can perform the job we have asked them to do. However, business associates are required by federal law to appropriately safeguard your information.

Research: We will disclose information to researchers after approval by an Institutional Review Board (IRB) in preparation for a research study, to recruit research subjects, or for a research study. The IRB reviews research proposals and establishes protocols to protect your safety and the privacy of your health information.

Special Privacy Protections for Alcohol and Drug Abuse Information: Alcohol and drug abuse information has special privacy protections. We will not disclose any information identifying an individual as being a patient or provide any health information relating to the patient's substance abuse treatment unless the patient consents in writing; a court order requires disclosure of the information; medical personnel need the information to meet a medical emergency; qualified personnel use the information for the purpose of conducting scientific research, management audits, financial audits, or program evaluation; or it is necessary to report a crime or a threat to commit a crime, or to report abuse or neglect as required by law.

YOUR HEALTH INFORMATION RIGHTS

Your medical record that is created after your physician has affiliated with TMH Physician Organization is the property of TMH Physician Organization. You have the following rights, with certain exceptions, regarding the health information that is created about you by TMH Physician Organization and its Physicians.

You have the right to a paper copy of this Notice. In addition, a copy of this Notice also may be obtained at our web site, www.methodisthealth.com.

Confidential Communications: You have the right to request that we communicate health information to you by an alternate means or location other than your home address and telephone number. Your request must be made in writing to TMH Physician Organization's contact person, and must specify how or where you wish to be contacted. We will try to accommodate your request for alternate communications. If you request an alternate means of communication, that request also should be communicated by you to all of your physicians, including your private physician.

Restrictions: You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we not use or disclose information to a family member about a surgery you had. To request a restriction, you must make your request in writing to the listed contact person. We are not required to agree to your request. If we do agree, our agreement must be in writing, and we will comply with your request unless the information is needed to provide you emergency treatment.

Additionally, you have the right to request that we not use or disclose information to a health plan for purposes of payment or health care operations (not for treatment) if the health information pertains solely to a health care item or service that has been paid for out-of-pocket and in full. Your request for restriction must be submitted in writing to our listed contact person. In this case, TMH Physician Organization must honor your request. However, you should be aware that such restrictions may have unintended consequences, particularly if other providers need to know that information (such as a pharmacy filling a prescription). It will be your obligation to notify any such other providers of this restriction. Additionally, such a restriction may impact your health plan's decision to pay for related care that you may not want to pay for out of pocket (and which would not be subject to the restriction).

Access: You have the right to review and obtain a copy of your health information, with certain exceptions. Usually, this includes medical and billing records, but does not include psychotherapy notes. Your request to review or obtain a copy of your health information must be in writing to our listed contact person. You will be charged fees as authorized by law. To the extent your information is held in an electronic health record, you may be able to receive the information in an electronic format.

Amendment: If you feel that the health information we have about you is incorrect or incomplete, you have the right to ask for an amendment of that information. You have the right to request an amendment for as long as the information is kept by or for us. Your request for an amendment must be made in writing to our listed contact person, and include a reason that supports your request.

Accounting of Disclosures: You have the right to receive a list of certain disclosures that we have made within the last six years of your health information. Your request for an accounting must be in writing to our listed contact person, and must state a time period for which you want an accounting. You may request one accounting free of charge within a 12-month period. A fee will be charged for additional lists within this same time period.

Breach Notification: In certain instances, you have the right to be notified in the event that we, or one of our Business Associates, discover an inappropriate use or disclosure of your health information. Notice of any such use or disclosure will be made in accordance with state and federal requirements.

Revisions of this Notice: We reserve the right to change this Notice, and the right to make the new provisions effective for all health information we currently maintain, as well as any information we receive in the future. If we make a major change to this Notice, the revised Notice will be posted in the individual offices of Physicians of TMH Physician Organization and on TMH Physician organization's web site. In addition, a paper copy of the revised Notice will be available upon request.

To Report a Complaint: If you believe your health information privacy rights have been violated, you can file a complaint with us or with the Secretary of the United States Department of Health and Human Services. There will not be any penalty or retaliation against you for making a complaint to us or to the Department of Health and Human Services.

Contact Person: If you have any questions or need information regarding our legal duties and privacy practices, or how to exercise any of your health information rights listed in this Notice, please contact:

Privacy Official
The Methodist Hospital System
1130 Earle Street AX200
Houston, Texas 77030
713.383.5129

Methodist The Methodist Hospital
Physician Organization

TMH PHYSICIAN ORGANIZATION AND ITS PHYSICIANS

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

You have been given the Notice of Privacy Practices for TMH Physician Organization and its Physicians. This Notice describes your legal rights regarding your health information and will inform you of the legal duties and privacy practices of TMH Physician Organization and its Physicians with respect to health information created for services generated by TMH Physician Organization and its Physicians. If you receive services by your physician or other health care provider at a different location, you may want to ask about that office or clinic's health information privacy policies and notices because they could be different.

Your name and signature below indicate that you have been provided with a copy of this Notice of Privacy Practices.

If you have a question regarding any of the information set forth in this Notice of Privacy Practices, please do not hesitate to call the Privacy Official at 713.383.5129.

Patient Name: _____

Signature of Patient or
Patient's Qualified Personal Representative: _____
Date _____

Printed Name of Qualified Personal Representative: _____

Legal Authority to Act on Behalf of the Patient: _____

Note: In the case of an Obstetrical patient, this signed acknowledgment for receipt of the Notice of Privacy Practices also serves as receipt of the Notice of Privacy Practices on behalf of the newborn(s).

For Staff Use Only

Date Acknowledgment noted in HIS/patient management system: _____

Comments if Notice not provided or Acknowledgment not obtained: _____
_____

Processed by: _____

Methodist The Methodist Hospital Physician Organization

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION AND PATIENT ACCESS

I. PATIENT INFORMATION

Patient Name: _____

Date of Birth: _____ Social Security Number: _____

Patient's Mailing Address: _____

_____

Telephone number: Work_____ Home_____ Cell_____

II. INFORMATION TO BE USED OR DISCLOSED

For Date(s) of Service: _____

Outpatient Clinic Record Billing Record

Films Pictures Other_____

I understand that information used or disclosed pursuant to this authorization form may include information relating to Human Immunodeficiency Virus (HIV), or Acquired Immunodeficiency Syndrome (AIDS); treatment for or history of drug or alcohol abuse; or mental or behavioral health or psychiatric care.

III. INFORMATION TO BE USED BY OR DISCLOSED TO:

Name of Recipient (Family Member): _____

_____

_____

_____

Telephone Number: _____ Fax Number: _____

IV. PURPOSE OF USE OR DISCLOSURE: _____

V. I authorize the use or disclosure of health information as described above. I understand:

- This authorization is valid for 180 days unless otherwise stated here: _____
- A photocopy or fax of this authorization is as valid as the original.
- I may revoke this authorization at any time by submitting a revocation in writing to [Methodist Urology Associates].
- If I revoke this authorization, the revocation will not apply to information that has already been released in good faith before the revocation was received.
- Treatment or payment may not be conditioned on my completion of this authorization form.
- If the Recipient identified above is not covered by Federal or Texas privacy laws, the information may not be protected under these laws once it is disclosed to the Recipient and, may be subject to re-disclosure by the Recipient.
- I may be asked to provide proof of my identity/guardianship with this authorization.
- Fees/charges will comply with all laws and regulations applicable to release of protected health information. Payment is due at time of release of information.

_____ _____

Signature of Patient or Qualified Personal Representative * **Date**

* If signed by a Qualified Personal Representative, the following must be completed:

Printed name of Qualified Personal Representative: _____

Legal Documentation showing Authority to Act on Behalf of the Patient: _____

(Example: Guardian of Patient, Executor of Estate)

For Internal Use Only

Verification of Signature/Authority: _____ Date: _____

Methodist Urology Associates
The Methodist Hospital Physician Organization
Medical Questionnaire

Dear Patient:

Please take a few minutes to complete this form. This will help assure you of the best possible care and will be held in confidence as part of your medical record. Information contained here will not be released to anyone without your authorization to do so.

NAME: _____ _____ _____ Today's Date: _____
Last First M.I.

Age: _____ Date of Birth ____/____/____ Occupation: _____
M D Y

Reason for this visit: _____ Referring M.D.: _____

Please tell us why you chose to come here for your medical care (check all appropriate answers):

- ☐ My personal physician recommended I come. ☐ My urologist recommended I come. If so, who _____
- ☐ A family member, acquaintance, or someone who was a patient recommended I come. If so, who _____
- ☐ Another physician recommended I come. If so, who _____
- ☐ I heard about the Methodist Urology Associates through a newspaper, magazine, bulletin, TV or radio.
- ☐ I came on my own to see Dr. _____ because I had heard about him/her.

	Still Alive		Age Now or at Time of Death	Cause of Death	Have they had any major illnesses? Please indicate for each relative.
	YES	NO			
Mother					
Father					
Brother					
Brother					
Sister					
Sister					

Please list prior major illnesses you have had and the approximate year:	YEAR	Please list prior hospitalizations you have had and the approximate year:	YEAR
_____	_____	_____	_____
_____	_____	_____	_____
_____		_____	_____

Please list surgical procedures you have had and the approximate year:	YEAR	Please list all medications you are taking. (Include non-prescription drugs.)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please indicate allergies to any medications:

Medication	Type of Reaction
_____	_____
_____	_____
_____	_____
_____	_____

Do you smoke now or in the past? No _____ Yes _____
Packs per day? _____ Years smoked? _____
If you have quit, please indicate year _____
Do you use recreational drugs? No _____ Yes _____
Explain: _____
Do you use alcohol? No _____ Yes _____
Explain: _____

Physician use only: (Comments/Notes)

I have reviewed the *Medical Questionnaire* with the patient. _____ _____
Physician Signature Date

REVIEW OF SYSTEMS

Do you now or have you had problems with any of the following?

	Y	N	Please explain any Yes answers.
General: Recent weight changes, fever, weakness, fatigue, headaches			
Integumentary: Rashes, eruptions, dryness, jaundice, changes in skin, hair or nails, discoloration of skin			
Eyes: Blurred vision, double vision, pain			
Ears, Nose, Mouth & Throat: Soreness and/or redness of gums, hoarseness, difficulty in swallowing, head colds, discharges, obstruction, postnasal drip, sinus pain, earaches			
Musculoskeletal: Joint pain, neck pain, back pain			
Respiratory: Chest pain, wheezing, cough, difficulty breathing, asthma, bronchitis, pneumonia, tuberculosis, shortness of breath, emphysema			
Neurologic: Fainting, blackouts, seizures, paralysis, tingling, tremors, memory loss, dizzy spells, stroke			
Cardiovascular: Chest pain, rheumatic fever, rapid heart beat, high blood pressure, swelling, dizziness, faintness, varicose veins, heart valve problems			
Endocrine: Thyroid trouble, fatigue, heat or cold intolerance, excessive sweating, thirst, hunger			
Gastrointestinal: Appetite, nausea, vomiting, diarrhea, constipation, indigestion, food intolerance, hemorrhoids, jaundice, heartburn, diabetes, hepatitis			
Genitourinary – Male: Hernias, testicular or penile problems, impotency, (erectile dysfunction), infertility, frequency or painful urination, blood in urine, urinary retention			
Genitourinary – Female: Vaginal pain, pain with sexual intercourse, low sexual desire, frequency or painful urination, blood in urine, urinary retention			
Hematologic/Lymphatic: Anemia, easy bruising or bleeding, past transfusions, swollen glands, blood clotting problems			
Psychologic: Nervousness, mood swings, insomnia, headache, nightmares, depression			
Allergy/Immunologic: Food allergies, plant allergies, environmental allergies			
Other AIDS, HIV			

Physician use only: (Comments/Notes)

I have reviewed the *Medical Questionnaire* with the patient. _____ _____

Faculty Signature Date

Patient Name _____ NPV ROV Date_____