University Urology, PC
Financial Policy and Patient Consent Form

Welcome to our office. Thank you for choosing University Urology, PC ("UU") for your urology needs. The following information is provided to avoid any misunderstanding concerning protected health information and payment for professional services.

1. **PAYMENT: Payment is expected at the time of service.** If your deductible has not been met, or a percentage is your responsibility, we expect payment when services are rendered. **Even though insurance will be filed, you are responsible for any balance after insurance processes your claim.** All charges for treatment become due and payable sixty (60) days after the date of service. These periods allow sufficient time to process insurance and make payment in full of any remaining balance. If not paid within 60 days, UU will begin various collection activities including, but not limited by submitting the past due account to a collection agency. At that time the decision could be made to terminate the doctor/patient relationship. There will be a $20.00 charge for returned checks. For your convenience we accept check, cash, Visa, MasterCard, American Express and Discover.

2. **SELF PAY PATIENTS:** New patients are required to bring a $500.00 deposit for their initial visit. If your balance is paid in full at the time of service, a discount offer will be made, if any overpayments have been made, a refund will be given. Prior to any surgery we ask that you coordinate your care with our business office. 865-305-9254

3. **MANAGED CARE: All managed care (HMO, PPO, etc.) co-payment amounts are due at the time of service.** If your insurance plan requires a referral authorization from a primary care physician please present this at your initial visit. If you request an office visit or surgery without a referral authorization your insurance plan may deem this as **"out of network" or "non covered" treatment**, and you will be responsible for a larger amount or all of the charges. By signing below, patient acknowledges that it is the patient responsibility to be aware of what services are covered and agrees to pay for any service deemed to be non covered or not authorized by the plan.

4. **MEDICARE:** UU are participating providers with the Medicare program and accept as payment, the Medicare allowable, patient deductible and/or 20% co-insurance. If you have supplemental insurance (Medigap) to cover the portion of the charges that Medicare does not pay, please provide us with a copy of your insurance card and any forms your insurance company may require. Medicare or secondary carriers do not cover some procedures and supplies. Please make certain you understand which aspects of your treatment are covered before proceeding. In this rare case you may be asked to sign a waiver form, which states that you understand that you will be responsible for these charges.

5. **CHILDREN OF DIVORCED PARENTS:** Responsibility for payment for treatment of minor children, whose parents are divorced, rests with the parent who seeks the treatment. Any court ordered responsibility judgment must be determined between the individuals involved, without the inclusion of UU.

6. **CLINICAL RESEARCH**: UU participates in clinical research studies, and UU physicians are compensated (receive money) by the study sponsors to perform research trials. Patient authorizes UU to access his/her medical information for the purpose of evaluating eligibility of patient for current or future clinical research studies. Patient agrees to be contacted by UU regarding the possibility of being enrolled in a research study. Patient is under no obligation to enroll in any study. Study participation is voluntary and refusal to participate will in no way involve penalty or loss of benefits to which the patient is otherwise entitled. Refusal to participate in a research study will not affect your continuing care with a UU physician. Participation in research study will not interrupt your regular care with a UU physician.

7. **SECONDARY INSURANCE:** The Tennessee Department of Insurance requires the patient to provide secondary insurance coverage to the provider if applicable. Patient agrees to notify provider in the future immediately of any additions, changes or deletions in primary or secondary insurance coverage.

8. **MEDICAL RECORDS AND FORM COMPLETION:** Please note that completing forms is both time consuming and costly. We will be happy to complete necessary forms for you at a rate of $25.00 per form. These forms are, but not limited to: Family Medical Leave Act (FMLA) forms and Disability Forms. The fee for making copies of medical records is $25.00. A Medical Record release form must be completed and signed by the patient before records will be allowed to leave our office. All fees will need to be paid in advance.

9. **MISSED APPOINTMENTS:** Please cancel your appointment at least 48 hours in advance. Last minute cancellations and no-shows make it difficult to serve other patients who are in need of medical care appointments. If you are scheduled for Urodynamics testing, and you do not cancel/reschedule your testing within 48 hours, you will be charged a fee of $100.00. We value our opportunity to help patients and provide a high level of quality care. We are a very busy practice and we want to be considerate to all our patients and their needs.

I have read, understood, and agreed to the above policies. If you have any questions or need clarification regarding these policies please call us at (865) 305-9254.

_____ / _____

Patient Name (Please Print) **Patient Date of Birth**

_____ / _____

Signature (Patient/Guardian) **Date**

Revised 04-10-2013

UNIVERSITY UROLOGY, PC

Disclosure Regarding Ancillary Services

Your physician may refer you for one or more "in-office ancillary services" in connection with your medical care. An "ancillary service" is a service provided to you by a third-party to aid in the diagnosis or treatment of an illness or injury related to your medical treatment. The types of ancillary services provided by our office are CT scans (computed tomography) and x-rays.

The physicians in this practice may have an economic interest in or other business relationship with the company used to provide this service. You are not obligated to use these services offered to you by our physician. You may choose to obtain these services at any other imaging facility. **We advise you to check with your insurance prior to scheduling any tests in order to verify coverage.** Below is a list of other local facilities that offer these diagnostic services:

University of Tennessee Medical Center
1924 Alcoa Highway
Knoxville, TN 37920
(865) 305-9000

Abercrombie Radiology
1112 East Weisgarber Road, Suite 201
Knoxville, TN 37907
(865) 588-1397

St. Mary's Medical Center-Campbell County
923 East Central Avenue
Lafollette, TN 37766
(423) 907-1200

Jellico Community Hospital
188 Hospital Lane
Jellico, TN 37762
(423) 784-7252

LeConte Medical Center
742 Middle Creek Road
Sevierville, TN 37862
(865) 453-9355

Athens Regional Medical Center
1114 W Madison Avenue
Athens, TN 37303
(423) 745-1411

Fort Sanders Regional
1901 W Clinch Avenue
Knoxville, TN 37916
(865) 541-1111

Jefferson Memorial Hospital
643 East Broadway Blvd.
Jefferson City, TN 37760
(865) 475-5632

Claiborne County Hospital
1850 Old Knoxville Road
Tazewell, TN 37879
(423) 626-4211

Woods Memorial Hospital
886 US Highway 411
Etowah, TN 37331
(423) 263-3600

Sweetwater Hospital
304 Wright Street
Sweetwater, TN 37874
(865) 213-8200

It is our policy that if any testing is acquired at an outside facility, it is the full responsibility of the patient to bring all reports and images on CD to the physician at the next appointment.

Title Transparency Disclosure

By law we are required to disclose every licensed employee with the description of their professional degree:

Frederick A. Klein- Medical Doctor

Edward D. Kim- Medical Doctor

W. Bedford Waters- Medical Doctor

Wesley M. White- Medical Doctor

Regula Doggweiler- Medical Doctor

Ryan B. Pickens- Medical Doctor

Patient/Guarantor Signature: _____Date: _____

University Urology, PC

HIPAA DISCLOSURE

I understand that under the Health Insurance Portability & Accountability Act, (HIPAA), of 1996 I have certain rights to privacy regarding my protected health information. Protected Health Information (PHI) may originate in my medical record at University Urology, P.C., (UU), or may be received from outside health entities and filed in my medical record. I understand that this information can and will be used by UU to: (a) conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in my treatment directly and indirectly, (b) obtain payment from third-party payers, (c) conduct normal healthcare operations such as quality assessments and physician certifications, (d) notification of educational events specific to my medical condition through UU or networking organizations, and (e) consent to property transfer of specimen (tissue obtained during a medical test) to UU.

I have been informed of your Notice of Privacy Practices which contains a more complete description of the uses and disclosures of my health information. I understand UU has the right to change its Notice of Privacy Practices from time to time and that I may obtain a current copy of the Notice of Privacy Practices from my local office or by contacting the Privacy Officer at 1928 Alcoa Highway, Suite 222, Knoxville, TN 37920. I understand that I may request, in writing, that UU restrict how my private information is used or disclosed to carry out my treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but, if I do agree, then I am bound to abide by such restrictions. I understand that I may revoke this consent in writing at any time except to the extent that I have taken action relying on this consent.

Signature: _____ **Date:** _____
Patient/Guardian

RELEASE OF INFORMATION AUTHORIZATION

- ❑ UU **may not** discuss my healthcare and **may not** discuss and/or make financial arrangements with any immediate family member.
- ❑ UU **may** discuss my healthcare and **may** discuss and/or make financial arrangements with any immediate family member.
- ❑ UU **may** discuss my healthcare and **may** discuss and/or make financial arrangements with **only the individuals listed below**:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I prefer to be contacted in the following manner:

Phone Number: _____

- ❑ *Leave message with detailed information.*
- ❑ *Leave message with contact number only.*
- ❑ Do not leave message.

Phone Number: _____

- ❑ Leave message with detailed information.
- ❑ Leave message with contact number only.
- ❑ Do not leave message.

I AUTHORIZE THE RELEASE OF MY MEDICAL RECORDS TO THE FOLLOWING INDIVIDUALS OR COMPANIES

- ☐ Regula Doggweiler, M.D.
- ☐ Edward D. Kim, M.D.
- ☐ Frederick A. Klein, M.D.
- ☐ W. Bedford Waters, M.D.
- ☐ Wesley M. White, M.D.
- ☐ Ryan B. Pickens, M.D.

Phone: 865-305-9254 **Fax: 865-305-4589**

Signature: _____ **Date:** _____
Patient/Guardian

ePrescribing Consent

ePrescribing is defined as a physician's ability to electronically send an accurate, error-free and understandable prescription to a pharmacy from the point of care. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. ePrescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) of 2003 listed standards that must be included in an ePrescribing program. These include:

- **Formulary and Benefit Transactions**: Gives the prescriber information about which drugs are covered by the drug benefit plan
- **Medication History Transactions**: Provides the physician with information about medications the patient is already taking to minimize the opportunity of potential adverse drug interaction
- **Fill Status Notification**: Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription was picked up, was not picked up or was partially filled

By signing this consent form, you are agreeing that University Urology can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payers for treatment purposes.

Understanding all of the above, I hereby provide informed consent to University Urology, P.C. to enroll me in the ePrescribe Program. I have had the opportunity to ask questions and all of my questions have been answered to my satisfaction.

Signature: _____ **Date:** _____
Patient/Guardian

UNIVERSITY UROLOGY
PERSONAL HEALTH INFORMATION

Name _____ Date of Birth _____

Primary Care Physician _____ Primary Care Physician Phone Number _____

Pharmacy Name _____ Pharmacy Phone Number _____

Pharmacy Address _____ City _____ ST _____ ZIP _____

Current Health Information

Height:_____ Weight:_____

DO YOU HAVE DRUG ALLERGIES? If so, please list below:

MEDICATION	What was your reaction?

ARE YOU ALLERGIC TO IV DYE? Yes No
DO YOU HAVE AN ALLERGY TO SHELLFISH? Yes No

Current Prescription Medications	Dose (Strength)	How Often (ex: once daily)

University Urology, PC

Patient Registration Form * Please Print All Information*

Patient's Name: (First) _____ (Middle) _____ (Last) _____

Address: _____ Apt./Lot #: _____

City: _____ State: _____Zip: _____ Email: _____

Main Contact # ( )_____Alternate # ( )_____

Date of Birth: ____/____/_____ Age: _____ □ Male □ Female SSN: _____

Referring Physician:_____ **Phone: ( )** _____

Primary Care Physician: _____ **Phone: ( )** _____

Employer: _____Occupation: _____ Phone: ( )_____

Mailing Address: _____ State: _____ Zip: _____

Employment Status: Full-Time Part-Time Not Employed Disabled
Retired Disabled Active Military

Marital Status: Married Single Widowed Divorced

Spouses' Name: _____ Date of Birth: ___/___/____ Contact # ( ) _____

Emergency Contact: _____ Relationship:_____ Phone: ( ) _____

Other Patient Information

Preferred Language English Spanish Other_____

To which racial category does the patient most closely identify?

□ African American □ Caucasian □ Filipino □ Japanese □ Native Hawaiian □ Pacific Islander
□ Asian □ Chinese □ Hispanic □ Native American □ Other: _____

Ethnicity

What is the patient's ethnicity? □ Hispanic or Latino □ Not Hispanic or Latino

Insurance Information

Do you have health insurance? YES NO (Give card's to the receptionist for a copy)

Primary Insurance: _____ Policy/ID#_____

Name of Policy Holder: _____ DOB _____Group/Acct # _____

Employer: _____ Employer Address: _____

City: _____ State: _____Zip: _____ Work # _____

Secondary Insurance: _____Policy/ID#_____

Name of Policy Holder: _____ DOB _____Group/Acct # _____

Employer: _____ Employer Address: _____

City: _____ State: _____Zip: _____ Work # _____

Assignment to Pay Insurance Benefits

I hereby assign all medical and/or surgical benefits, to which I am entitled, including Medicare, private insurance and any other health plans to University Urology, PC. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure this payment. I understand that failure to notify University Urology of any changes or insurance coverage will result in the financial obligation to rest fully on myself regardless of any contract between the insurance company and University Urology.

Signature: _____ Date: _____
Patient/Guardian