GARDEN STATE UROLOGY

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TODAYS DATE_____

HISTORY FORM

Patient Name: _____ DOB: _____

Primary Care Physician Name: _____ Phone: _____

Other Treating Physician Name: _____ Phone: _____

Other Treating Physician Name: _____ Phone: _____

Pharmacy Name: _____ Phone: _____

Pharmacy Address:_____City:_____State:_____Zip:_____

Reason for today's visit (New Patients ONLY)_____

Medications: Please list all the medications you are currently taking (including OTC medications such as aspirin), dosage and frequency. For example: *Aspirin 325mg daily.*

Medication	**Dosage**	**Frequency**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

****If you are unable to fit all medications on the above list, please attach an additional page****

Allergies: Please list any drug allergies (including latex and shellfish, if applicable.)

_____

Social History:

Occupation: _____ Marital Status: _____ # of Children: _____

Do you currently smoke? YES NO Did you ever smoke? YES NO

How many packs per day? _____ When did you quit? _____

Do you drink alcohol? YES NO How many drinks per week? _____

Family History: Do you have a family history of any of the following?

Prostate Cancer YES NO Bladder Cancer YES NO Kidney Cancer YES NO

Please list all serious illnesses in your family and indicate the relationship to you:

_____

_____

Race (Optional): (Requested by the state of New Jersey for the Cancer Registry)

___Caucasian ___African American ___American Indian ___Asian Indian/Pakistani

___Hispanic ___Asian ___Other_____

Past Medical History: Do you have or have you had any of the following medical conditions?

Diabetes	YES	NO	Heart Disease	Yes	NO	Arthritis	YES	NO
Asthma	YES	NO	Thyroid Disease	YES	NO	GERD	YES	NO
High Blood Pressure	YES	NO	Cancer	YES	NO	Other (please list):		

Past Surgical History: Please list all surgeries/procedures. Include approximate dates, if possible.

Procedure	Date
_____	_____
_____	_____
_____	_____
_____	_____

Review of Symptoms: Please circle YES or NO if you experience the following symptoms.

Constitutional			**Gastrointestinal**			**Respiratory**		
Fever	YES	NO	Abdominal pain	YES	NO	Emphysema	YES	NO
Chills	YES	NO	Nausea/Vomiting	YES	NO	Shortness of breath	YES	NO
Other	YES	NO	Other	YES	NO	Other	YES	NO
Neurological			**Psychological**			**Integumentary**		
Tremors	YES	NO	Depression	YES	NO	Skin Rash	YES	NO
Dizzy Spells	YES	NO	Psychosis	YES	NO	Persistent Itch	YES	NO
Other	YES	NO	Other	YES	NO	Other	YES	NO
Hematological/Lymphatic			**Cardiovascular**			**Genitourinary**		
Clotting problem	YES	NO	Chest Pain	YES	NO	Urinary Tract Infection	YES	NO
Swollen glands	YES	NO	Heart Attack	YES	NO			
Blood transfusion	YES	NO	Heart Murmur	YES	NO	Blood in Urine	YES	NO
Other	YES	NO	Other	YES	NO	Erectile Dysfunction	YES	NO
						Kidney Stones	YES	NO
						Other		
Musculoskeletal			**Endocrine**					
Joint Pain	YES	NO	Excessive Thirst	YES	NO			
Neck Pain	YES	NO	Tired/Sluggish	YES	NO			
Other	YES	NO	Diabetes Mellitus	YES	NO			
			Other	YES	NO			

Provider reviewed/Date:_____ **Provider reviewed/Date:**_____ **Provider reviewed/Date:** _____

Provider reviewed/Date:_____ **Provider reviewed/Date:**_____ **Provider reviewed/Date:** _____

Patient Comments: Please comment on any issues/problems not covered in the above questions.

_____

_____

Patient Signature:_____ **Date:**_____

ADULT REGISTRATION FORM: Please complete the entire registration form.

Physician you are here to see: _____

Patient's Name: _____ **Home Phone#:** _____
First Middle Last

Work phone #: _____

Street Address: _____
City: _____ State: _____ Zip Code: _____ **Cell Phone #:** _____

Patient Social Security#: _____ Patient's Sex: Male Female

Patient Date of Birth: _____ Patient Marital Status: M S D W

Employer: _____ Occupation: _____ Address: _____

Email address: _____

Spouse's Full Name: _____ Cell/Work #: _____
Emergency Contact: _____ Home/Cell #: _____ Relationship: _____

Primary Care Doctor: _____ Phone: _____ Address: _____

Doctor who Referred you (if different from primary): _____ Phone: _____ Address: _____

Pharmacy Name: _____ Town: _____ Phone#: _____

INSURANCE INFORMATION **(Must be completed in full so that we may submit to your insurance for reimbursement.)**
Primary Insurance: _____

Policyholder's name (insured's name): _____ Date of Birth: _____

Sex: Male Female Social Security #: _____ Employer: _____

Patient's relationship to insured (please circle): Self Spouse Child Other/Dependent

Group Number: _____ Policy Number: _____

Secondary Insurance: _____

Policyholder's name (insured's name): _____ Date of Birth: _____

Sex: Male Female Social Security #: _____ Employer: _____

Patient's relationship to insured (please circle): Self Spouse Child Other/Dependent

Group Number: _____ Policy Number: _____

I request that payment of authorized Medicare, Medicaid, and/or commercial insurance benefits be made to Garden State Urology for any service furnished to me by GSU's physicians. I authorize Garden State Urology to release medical information which may be required by my insurance carrier to determine payment for services rendered. I further understand that I am responsible to pay certain amounts due the physician. These amounts could include annual deductibles, co-payments, charges denied as not covered by Medicare or my insurance program, and charges denied for services determined as not medically necessary. I further understand that if GSU incurs any fees associated with collecting reimbursement on my account, I will be responsible for paying those fees.

Signature: _____ **Date:** _____

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PATIENT NAME: _____ **DATE OF BIRTH:** _____

ACKNOWLEDGEMENT FORM FOR THE FINANCIAL INFORMATION DOCUMENT

Attached is Garden State Urology Financial Information Document. This document explains the following information:

- In-network financial responsibility
- Out-of-network financial responsibility
- Self Pay / no insurance
- Medicaid/Charity Care
- Collections
- Precertification/authorization

Please take a few moments to read the document and save it with your medical records for future reference.

If you have any questions or concerns after reading the document, please ask to speak to a Financial Counselor.

In order to document for our records that you received this document we require all patients/guarantors to sign below acknowledging receipt of the document.

I acknowledge receipt of Garden State Urology's Financial Information Sheet that explains the information as outlined above.

Patient/Guarantor Signature _____ Date:_____

For patients with Blue Shield or Horizon Insurance who are seeing an out of network physician:

Unfortunately, these insurance carriers will not send payment directly to an out of network physician. All payments/ explanations of benefits are sent to the patient/guardian.

When you receive an explanation of benefit/payment for a service rendered by Garden State Urology contact the Billing Department IMMEDIATELY.

DO NOT WAIT until you receive a statement or phone call from us.

Internal Use Only:

If patient or patient's representative refuses to sign acknowledgement of receipt of the Payment Summary Sheet, please document the date and time the notice was presented to patient and sign below.

Date: _____ Time: _____ Employee Name: _____

G:\GSU BILLING POLICIES\GSU Financial acknowledgment form.doc

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Garden State Urology Financial Information Document

Please take a few moments to read this Financial Information Document.

We are committed to giving you the best possible care, and we are pleased to discuss the details of the Payment Information Sheet with you at any time. We welcome you as our patient and we will work with you to help you understand your financial responsibility for urological care. In today's health care world, every patient's insurance coverage is different. Even patients who qualify for government insurance such as Medicare may have different coverage terms. If you have questions or need assistance, please contact our Central Business Office Management Team directly at (973) 240-2181. Please keep this document with your medical records so you will have it for future reference.

We will submit all insurance claims (in or out of network) on your behalf.

For your convenience, we accept payment by cash, check, money order, Visa, MasterCard, American Express and Discover.

This Payment Information Sheet explains four different financial categories: in network participation with your insurance, out-of-network insurance, self-pay (no insurance), Medicaid/Charity Care. Please read the category that applies to you CAREFULLY.

1. IN NETWORK (UROLOGIST PARTICIPATES WITH YOUR INSURANCE):

If your urologist is a participating physician in your insurance plan, he/she has a contract and must abide by that contract. Your responsibilities are as follows:

(a) **Co-pay** - Payment of all copayments is due at the time of service.

(b) **Referrals** - If your insurance plan requires a referral, it is your responsibility to bring it with you to the appointment and make sure it is valid for future visits. If you do not have a valid referral you must pay for the visit in full at the time of the appointment or reschedule to a future date.

(c) **Deductible** - You are financially responsible for payment of the deductible. If your deductible has not been met and is $500 or more, you may be required to pay the deductible prior to treatment or surgery. The Practice Manager/designated employee will contact you about payment arrangements.

(d) **Coinsurance** - You are financially responsible for the coinsurance if it is applied by your insurance plan. This is typically not determined until after the insurance plan has processed the claim.

(e) **Non-covered services** - Your insurance plan may not cover all medical services. Our staff will attempt to determine what is covered prior to treatment and inform you before services are rendered. In some circumstances, coverage cannot be determined until the claim is processed. Non-covered services are your financial responsibility.

NOTE: The physicians' participation status may change in the future.

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2. **OUT-OF-NETWORK – (UROLOGIST IS NON-PARTICIPATING WITH YOUR INSURANCE):**
If your urologist is not a participating provider with your health plan, he/she is considered to be out of network. Most insurance products have optional "Out-of-Network" benefits (traditional, PPO, or POS plans). Out-of-network benefits STILL provide coverage for "out-of-network" physicians. See section entitled "Insurance Without an out-of-network option for further explanation.

(a) Insurance WITH an "Out-of-Network" Option:

a. Office visits – Payment in full for the office visit is required at the time of the appointment. Our initial consultation fee ranges from $200-$300. The follow up office visit fee ranges from $100-$200.

b. Other services – biopsies, cystoscopies, injections, surgery, ultrasounds, urodynamics, etc. :

i. These charges will be submitted to your insurance company first.

ii. Once your insurance company process the claims, you **will** be responsible for any charges applied to your deductible, if any.

iii. If your deductible is $500 or more you may be required to pay the deductible prior to treatment or surgery. The Practice Manager/designated employee will contact you about payment arrangements.

iv. If the physician is "Out-of-Network" he is not contractually bound by a contract to the insurance company. We **may** elect to waive or accept reduced co-insurance from beneficiaries of insurance plans with which we are NOT contractually bound. Please see our Compassionate Billing Policy for additional information.

c. Biofeedback or pelvic muscle rehabilitation – These services are typically provided one time a week for 6 to 10 weeks. We will verify your insurance benefits prior to treatment. Depending on your plan we may need to collect payment in advance. The Practice Manager/designated employee will contact you about payment arrangements.

NOTE: In certain circumstances, such as when an insurance plan reimburses out of network claims at a reduced rate (Some out of state Blue Shield plans, some United Health Care Choice Plus plans, and some local union self insured plans), or an international plan, the Practice Manager or Financial Counselor will discuss payment arrangements with you prior to the procedure or surgery.

(b) Insurance WITH NO "Out-of-Network" Option (HMO plans)

A few insurance plans do not include coverage for Out-of-Network" services – these are usually very strict HMO plans. If your plan does not include an Out-of-Network" option, the insurance company will not cover your medical bills unless it was an emergency. You will be responsible for full payment at the time of service. You may speak to the CBO Management Team regarding arranging a payment plan in such circumstances. Alternatively, you may need to seek treatment from an urologist in the network.

3. **SELF-PAY/NO INSURANCE**
Payment in full is required at the time of the appointment. Our initial office visit fee ranges from $200 to $300. Follow up visit fees range from $100-$200. If additional services are necessary you may speak to the CBO Management Team regarding arranging a payment plan.

4. **MEDICAID AND CHARITY CARE**:

The physicians are NOT participating providers with Medicaid. Therefore, Medicaid will not pay for services rendered by physicians of Garden State Urology. Further, the physicians do not provide charity care through Garden State Urology. Therefore, if you have Medicaid or were approved for charity care, you are still financially responsible for services rendered at Garden State Urology. We may offer reduced fees upon receipt of a completed financial application and submission of requested financial information and in accordance with our Compassionate Billing Policy.

5. **INFORMATION FOR ALL PATIENTS**:

(a) **Precertification/authorizations** –

i. **Surgery** - If you are scheduled for a surgery with a urologist at Garden State Urology our surgical scheduling staff will call to obtain a pre-certification number.

ii. **Testing such as MRI, CAT scans, etc**. - If your physician ordered testing to be done outside of Garden State Urology it is your responsibility to check with the radiology facility AND your insurance if your plan requires a precert/authorization. If it does, then you must call your urologist's office and provide them with the required information (facility and date) so that they can obtain a pre-certification/authorization for you.

iii. **Testing such as laboratory**- If your physician ordered laboratory testing to be done outside of Garden State Urology it is your responsibility to check with the laboratory AND your insurance if your plan considers the laboratory to be a participating facility.

(b) **Secondary/Tertiary Insurance** - If you have secondary insurance coverage you must provide that information on the date of service.

(c) **Return Check Fees** - You will be charged a $25 processing fee for any personal checks returned for non-payment.

(d) **Insurance Changes** - If your insurance changes, please notify us as soon as possible so we can make the appropriate changes.

(e) **Collections** - We only send you a bill/statement when the insurance company has already processed the claim and outlined your financial responsibility or we have not had any response from your insurance carrier. If you receive a bill from us, our records indicate that the balance on the account is YOUR responsibility. If you have a question about a bill, call our Billing Department immediately.

PLEASE DO NOT IGNORE your statements!

Garden State Urology Central Business Office 16 Eden Lane PO Box 912 Whippany, NJ 07981
Phone: 973.240-2181 <> **Fax:** 973.599-1695

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Our representatives are available to help with payment arrangements if you contact us IMMEDIATELY. Failure to respond to repeated communications from our office may result in discharge from the practice and/or involvement of an outside collection agency.

If you have not made payments on your account and if there has been no attempt to contact our office with regard to financial arrangements for more than 60 days, your account may be assigned to a collection agency.

We firmly believe that a good doctor –patient relationship is based on understanding and open communication. Our staff will make reasonable efforts to clarify any misunderstandings you may have concerning payment for your treatment.

If you have any questions, please contact our Billing Department directly at (973) 240-2181.

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