



# WESTERN MICHIGAN UROLOGICAL ASSOCIATES, PLC

## WELCOME TO OUR PRACTICE

Account # \_\_\_\_\_

Thank you for selecting our healthcare team. We are committed to providing you with the best possible care. Please fill out the form completely. If you need assistance, we will be happy to help.

<b>Patient Information</b>		Date _____
Name _____		Home Phone _____
Address _____		Cell Phone _____
City _____ State _____ Zip _____		Work Phone _____
Employer /School _____		Which number should we use as primary number? _____
Emergency Name _____		Birth Date _____ Age _____
Emergency Number _____		SS # _____
Sex: M / F      Marital Status:    S    M    D    W		email address _____
Family Dr. _____		How did you hear about our office? referred, friend, yellow pages, other _____
Preferred Pharmacy _____	Address _____	Phone # _____

### If Patient Is Minor:

#### Father's Information

Name \_\_\_\_\_

Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_

#### Mother's Information

Name \_\_\_\_\_

Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_

<b>Primary Insurance</b>	<b>Secondary Insurance</b>
Insurance Company _____	Insurance Company _____
Cardholder's Name _____	Cardholder's Name _____
Relationship to Patient _____	Relationship to Patient _____
Cardholder's Birthdate _____	Cardholder's Birthdate _____
Social Security # _____	Social Security # _____
Home Phone # _____	Home Phone # _____
Cell Phone # _____	Cell Phone # _____
Work Phone # _____	Work Phone # _____
Employer _____	Employer _____
Group # _____	Group # _____
Contract _____	Contract _____
Effective Date _____/Copay \$ _____	Effective Date _____/Copay \$ _____

### HIPAA Acknowledgment of Receipt

I have received a copy of the Notice of Privacy Practices (NPP).

Patient/Personal Representative Signature \_\_\_\_\_

Print Name / Relationship \_\_\_\_\_/\_\_\_\_\_

Date \_\_\_\_\_

OVER

# WESTERN MICHIGAN UROLOGICAL ASSOCIATES, PLC

## Insurance

We will bill your insurance carrier as a courtesy to you, however payment for deductible and copay is due at the time of service. This includes all office visits, procedures, and injections. If you do not have your copay with you, your appointment may be rescheduled. Please remember... Your insurance coverage is a contract between you and your insurance company and **not** a substitute for payment.

We participate with Medicare, BCBS and many of the area employer plans. Please ask us if you are unsure whether we participate with your plan.

## Referrals / Prior Authorizations

If your insurance has designated a primary care physician (PCP), you are required to have authorization from your PCP prior to your visit. If authorization is not provided, you will be asked to either reschedule your appointment or pay for your visit in full at the time of service. / **Prior Authorization:** Some insurances require prior authorization for procedures done in the office, this will be the patient's responsibility to check with their insurance prior to their visit to avoid possible higher deductible or copay charges.

## Self-Pay Accounts / Plans We Don't Participate With

Self-pay accounts are patients that have no insurance coverage, have not met their deductible or are covered by insurance plans we do not participate with. Payment must be made at the time of service. If this is not possible, please discuss the situation with the billing department **before** your scheduled appointment.

**On occasion a phone call from a physician or nurse for medical evaluation or symptom management might be requested by a patient. We offer that service for your convenience, however there may be a charge incurred for this service.**

## Payment Methods

For your convenience, we accept the following methods of payment: Cash, Personal Check, Visa, MasterCard, Discover.

## Delinquent Accounts / No-Show Policy

In the event that your account should become delinquent, an outside collection agency may be utilized. / **No Show Policy:** If we do not receive a 24 hr. notice of a cancelled appointment, the **patient** will be charged at the time of the second (2nd) No-show/No-notification appointment.

## Authorization and Release

I authorize payment of medical benefits be made directly to Western Michigan Urological Associates, PLC. I understand the financial policy and accept the personal responsibility for payment of covered and non-covered services. I authorize the release of any medical or other information necessary to process my claims.

Patient/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

## Medicare Information/Authorization

Number	Primary? <input type="checkbox"/> Yes <input type="checkbox"/> No	Medicare Part B? <input type="checkbox"/> Yes <input type="checkbox"/> No
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I request that payment of authorized Medicare benefits be made to Western Michigan Urological Associates, PLC. I authorize any holder of medical information about me, needed to determine those benefits or the benefits payable for related services, to be released to the Health Care Financing Administration or its agents. I also authorize Medicare to send Explanation of Medicare Benefits information to my Medicare supplement and benefits to be paid to Western Michigan Urological Associates, PLC, for any services furnished to me until further notice. I authorize any holder of information about me, needed to determine those benefits or the benefits payable for related services, to be released to the Health Care Financing Administration, or its agents.

Signature \_\_\_\_\_ Date \_\_\_\_\_