METROPOLITAN
UROLOGICAL SPECIALISTS

Patient Data Sheet

Referred by:_____ Primary Care Physician:_____

I. PATIENT INFO:

Name:_____
(Last Name) (First Name) (Middle Initial)

Address:_____
(Street Address) (City/State) (Zip Code)

Home Phone:_____Cell Phone:_____Work Phone:_____

Date of Birth:_____(*If 26 years old or younger please fill out Section II: Parent/Guardian)

Marital Status: S M W D Separated (**If married please fill out Section III: Spouse)

Gender: M F SSN:_____E-mail Address:_____

Ethnicity: Hispanic or Latino Not Hispanic or Latino

Choose one or more of the following
Race: Asian Native Hawaiian or other Pacific Islander Black/African American White

Hispanic or Latino American Indian or Alaska Native Other

Preferred Language: _____

Employed: Full-Time Part-Time N/A - Employer Name:_____

Are you a student: Full-Time Part-Time N/A

What Pharmacy do you use?_____Phone_____
(Pharmacy Name) (Street Name)

II. PARENT/GUARDIAN INFORMATION for all patients age 26 or younger

Name _____ Relationship_____DOB _____
(Last Name) (First Name)

Name _____ Relationship_____DOB _____
(Last Name) (First Name)

Name _____ Relationship_____DOB _____
(Last Name) (First Name)

Address (if different from above)_____

Phone# _____

III. SPOUSE INFORMATION:

Name:_____
(Last Name) (First Name) (Middle Initial)

Address: (If different than above)_____

SSN _____ Date of Birth _____

Employed: Full-Time Part-Time N/A - Employer Name: _____

IV. INSURANCE:

Copy of insurance card required:

Primary Insurance:_____

Member/Subscriber Name:_____Relationship to Patient:_____

Secondary Insurance:_____

Member/Subscriber Name:_____Relationship to Patient:_____

If insurance coverage provided through spouse or parent please make sure all information given in those sections.

V. RESPONSIBLE PARTY

If there is a patient balance who is responsible for the bill? Patient or

_____Relationship_____
(Last Name) (First Name)

_____
(Address) (City, State, Zip) (Phone Number)

SSN_____

VI. AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION:

1. Please name anyone that the doctor, nurse or representative of our office is allowed to speak to regarding your health information:

Name:_____Relationship: _____

Name:_____Relationship: _____

Name:_____Relationship: _____

2. We need to know if you allow us to leave a message on your voice mail or recorder; such messages could be appointment reminders, normal test results, and/or billing information.

Yes No

At Home _____

On Cell _____

At Work _____

3. If you would like to revoke or change this authorization please send request in writing to: HIPAA Privacy Officer at 207 Chesterfield Towne Centre, Chesterfield, MO 63005.

I am confirming my authorization for use and/or disclosure of my protected health information with the people named in this form.

Signature:_____Date: _____

If this authorization is signed by a personal representative for the individual patient, please list reason patient is unable to sign _____

Personal Representative's Name_____
(Print)

Relationship to Patient: _____

FINANCIAL AGREEMENT

The physicians and staff of Metropolitan Urological Specialists are committed to providing you with the best possible care and are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy or your financial responsibility.

PATIENTS MUST FILL OUT PATIENT INFORMATION FORMS PRIOR TO SEEING THE DOCTOR. WE WILL REQUEST TO PHOTOCOPY YOUR INSURANCE CARD(S) AND A PHOTO I.D. FOR YOUR FILE. ANYTIME YOU CHANGE INSURANCE PLEASE UPDATE US WITH YOUR NEW INSURANCE INFORMATION SO WE CAN PROPERLY FILE YOUR CLAIM.

- **APPOINTMENTS** – 24 hours' notice must be provided in the event you cannot keep an appointment. Should you not provide this notice; a cancellation fee of $40.00 may then be added to your account. Cancellations for Procedures or Ancillary Services will have a higher fee.
- **REFERRALS** – If your plan requires a referral from your primary care physician, it is **YOUR** responsibility to obtain it prior to your appointment and have it with you at the time of your visit. If we do not have your referral at the time of visit you will be asked to reschedule the appointment until you obtain a proper referral.
- **CO-PAYMENTS** – By law we MUST collect your carrier designated co-pay. This payment is expected at the time of service. Please be prepared to pay the co-pay at each visit. Should you not pay at the time of service, and we subsequently send you a statement, an administrative fee of $5.00 may be added to your account. Any procedure performed in this office could be deemed surgical by your insurance company and all copays and deductibles will apply.
- **FMLA AND/OR WORKMAN COMP FORMS** – We will complete one set of FMLA or Workman Comp Forms. There will be a $25 charge for the completion of additional Workman Comp or FMLA forms.
- **SURGERY DEPOSITS** – If you and your physician determine that your course of care requires surgery, a surgical deposit may be collected at the time of scheduling. Our scheduling coordinators will work with you to determine estimated insurance payment and estimated patient responsibility.
- **OUT OF NETWORK PLANS** – You will be responsible for any balance your plan indicates is due on their explanation of benefits form. We will adjust the charges to coincide with your plan's UCR (Usual, Customary and Reasonable) charges. All patients will be responsible for their co-insurance and deductible. If we do not "participate" with your plan, we will send a courtesy bill to that carrier on your behalf. However, should they not pay your claim within 45 days; you will be responsible for the full amount due. Should you receive payment from your insurance carrier, please forward it to the physician's office.

  - Private Insurance Authorization for Assignment of Benefits/ Information Release: I, the undersigned, authorize payment of medical benefits to Metropolitan Urological Specialists, PC for any services furnished. I understand that I am financially responsible for any amount not covered by my contract. I also authorize any holder of medical information about me to release to my insurance company (or the agent) information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

- **SELF-PAY PATIENTS** – Payment is expected at the time of service unless other financial arrangements have been made prior to your visit.
- **MEDICARE** – We will submit claims to Medicare. The patient will be responsible for the deductible and the 20% co-insurance, which can be billed to a secondary insurance if you have one.

  - Medicare Lifetime Signature on File: I request that payment of authorized Medicare benefits to be made on my behalf to Metropolitan Urological Specialists, PC for any services furnished to me. I authorize any holder of medical information about me to release to the CMS (and its agents) any information to determine these benefits payable for related services. This information will be used for the purpose of evaluation and administering claims of benefits.

- **INSUFFICIENT FUND CHECKS** – A $25.00 fee will be charged to patient's account for checks returned due to non-sufficient funds.

You are responsible for the timely payment of your account. Should it become necessary for us to use an outside agency to collect payment from you, you will be additionally responsible for whatever charges we incur as a result of this.

WE ACCEPT CASH, CHECKS, MASTERCARD, VISA, DISCOVER AND CARE CREDIT.
THANK YOU for taking time to review our policies.

Patient's Name: _____ DOB _____

Responsible Party Signature _____ DATE: _____