JERRY J. TRULSON, M.D.
ERIC I. VOGT, M.D.
DOUGLAS A. WEST, M.D.

UROLOGY CARE, INC.
3207 WEST TRUMAN BOULEVARD
JEFFERSON CITY, MISSOURI 65109-0578

(573) 636-5115
FAX (573) 636-2818

Dear Patient,

The Physicians and Staff at Urology Care, Inc. welcomes you. We are pleased that your or your physician as selected us to be a part of your healthcare.

PAYMENT POLICIES

TRADITIONAL MEDICARE PATIENTS: You will **NOT** be paying on the date of your visit as we take assignment on Medicare. This means we accept Medicare's allowed amount. We write off everything that Medicare does not allow, but **YOU ARE RESPONSIBLE** for the remaining amount which is usually 20%; if you have met your deductible for the year.

MANAGED MEDICARE PATIENTS: You are responsible for your co-pay on the date of service.

INSURED PATIENTS: We will collect your co-pay at the time of service. your co-pay is generally stated on your insurance card. **WE WILL FILE YOUR CLAIM.**

MANAGED CARE: If you belong to a managed care plan that requires a referral from your primary care physician, it is YOUR responsibility to obtain this referral. **WE MUST HAVE A REFERRAL FORM OR NUMBER AT THE TIME OF YOUR VISIT, OR YOUR APPOINTMENT WILL BE RESCHEDULED.**

NON-INSURED PATIENTS: We request payment in full at the time of service, unless prior arrangements have been made.

VASECTOMY PATIENTS: Vasectomies are considered an elective procedure. If your insurance does not cover this procedure, we will ask for full payment on the day of your procedure. The procedure will not be done on the first visit, this is a consultation visit **ONLY.** The consultation fee is $225. The fee for vasectomy with insurance is $600 and a vasectomy without insurance is $900, these fees are due at time of consultation / procedure. **WE ASK YOU TO PLEASE PROVIDE YOUR INSURANCE CARD BEFORE YOUR CONSULTATION SO WE ARE ABLE TO GET BENEFITS ON BOTH THE CONSULT AND THE PROCEDURE.**

PLEASE BRING YOUR INSURANCE AND/OR MEDICARE CARDS TO YOUR APPOINTMENT. IF YOU CANNOT PROVIDE YOUR CARDS, YOU WILL BE CONSIDERED SELF-PAY AND WILL BE EXPECTED TO PAY ON THE DAY OF SERVICE.

BE PREPARED TO PAY YOUR CO-PAY ON THE DAY OF YOUR VISIT.

Please return the patient information sheets in the provied self-addressed, stamped envelope as soon as possible, as this will speed the check-in process on your first visit.

If you are **UNABLE** to keep your appointment, please call us at 573-636-5115 and give us AT LEAST 24-hour notice.

We look forward to seeing you at your appointment.

UROLOGY CARE PATIENT INFORMATION

PLEASE PRINT LEGIBLE

PLEASE ANSWER ALL QUESTIONS

Patient's Full Name _____ Date of Birth _____ Age _____

Street Address, Route, P.O. Box _____ City _____ State _____ Zip Code _____

Social Security Number _____ Marital Status: S M W D

Email _____ Home Phone _____

Cell Phone _____ Cell Phone Carries _____

Patient's Employer _____ Occupation _____ Work Phone _____

Spouse's Name _____ Spouse's Employer _____ Spouse's Work Phone _____

PLEASE FILL OUT THIS SECTION IF PATIENT IS A MINOR OR HAS A GUARDIAN

Parent/Guardians Name _____ Address _____ Home Phone _____

Parents or Guardians Employer _____ Work Phone _____

EMERGENCY CONTACT, SOMEONE OUTSIDE THE HOUSEHOLD

Name _____ Phone Number _____

If you were referred by a Physician, Please list Name and Phone Number:

_____

Allergies, Medications, Please list:

_____

Are you allergic to Iodine, or have problems with x-ray studies: _____ Yes _____ No

Current Medication you are taking, including Minerals and vitamins: _____

_____

_____

Pharmacy Name and Number

_____

INSURANCE INFORMATION (IF YOUR CARD WAS SCANNED, DO NOT NEED TO FILL OUT)

Medicare Number _____ Medicaid Number _____

Name of Insurance _____ ID/Policy# _____ GP # _____ Subscriber _____

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I authorize the release of any medical information necessary to process insurance claims.

SIGNED _____ DATE _____

AUTHORIZATION TO PAY INSURANCE BENEFITS AND/OR GOVERNMENT BENEFITS

I authorize payment directly to the doctors of Urology Care, Inc., and I am financially responsible for charges not covered

SIGNED _____ DATE _____

Urology Care, Inc
3207 West Truman Boulevard
Jefferson City, MO 65109
Phone: 573-636-5115 / Fax: 573-636-2818

Douglas West, MD **Jerry Trulson, MD** **Eric Vogt, MD**

DISCLOSURE / AGREEMENT

I agree to pay for any and all medical services I receive from the doctors/providers of this practice that my insurance company refuses to pay, for whatever reason. I understand that this office will file a claim on my behalf, however, if my insurance company refuses to pay, I will be held liable for the balance. This includes any and all non-covered services.
If I choose to see my physician without a referral I understand I will be responsible for all charges, to be paid the day of my appointment. I will be willing to pay, or make arrangements for payment with 45 days of refusals of payment. Failure to do so will be a refusal of payment.

I furger agree and understand that this office can only code and file a claim for my visit with a diagnosis that was encountered and documented in my medical chart. Thus, to ask this office to change a diagnosis code solely for the purpose of securing reimbursement from my carrier is inappropriate and may result in fraudulent acts.

If insurance requires a referral, and is not obtained before visit, appointments will be rescheduled. This is my responsibility prior to my visit.

Print Name:_____ DOB: _____

Patient Signature:_____ Date: _____

Witness Signature: _____

We gladly accept Visa, Mastercard, Discover, Cash and Checks from a local bank.

ELISE PILGER, N.P.
JERRY J. TRULSON, M.D.
ERIC I.VOGT, M.D.
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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement but, in refusing we *will not be allowed* to process your insurance claims.

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for _____. A copy of this signed, dated Acknowledgement shall be as effective as the original.

_____ _____

Please ***print*** your name Please ***sign*** your name

_____ _____

Legal Representative Description of Authority

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTHCARE INFORMATION:
(This includes step parents, grandparents and any care takers who can have access to this patient's records):
Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY HEALTHCARE APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

- ☐ Cell Phone Confirmation
- ☐ Home Phone Confirmation
- ☐ Work Phone Confirmation
- ☐ Text Message to my Cell Phone
- ☐ Email Confirmation
- ☐ U. S. Mail / Postcard

I AUTHORIZE **INFORMATION ABOUT MY HEALTHCARE HEALTH** BE CONVEYED VIA:

- ☐ Message on Cell Phone
- ☐ Message on Home Phone
- ☐ Message on Work Phone
- ☐ Text Message
- ☐ Email Message
- ☐ U. S. Mail / Postcard
- ☐ **Any of the above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS or NEW HEALTHCARE INFO** via:

- ☐ Phone Message
- ☐ Text Message
- ☐ Email
- ☐ U. S. Mail / Postcard
- ☐ **Any of the above**

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

It was emergency treatment ____
I could not communicate with the patient ____
The patient refused to sign ____
The patient was unable to sign because ____
Other (please describe) ____

_____

Signature of Privacy Officer

PATIENT HISTORY FORM (PLEASE PRINT)

Last Name: _____ **First Name:** _____ **MI** _____

Date of Birth: _____ **Weight:** _____ **Height:** _____

What is the main reason for your visit? (Describe the problem in detail) **Today's Date:** _____

_____

_____

PAST MEDICAL HISTORY

List any personal illnesses/diagnosis/disease you are being treated for: Example (Bladder Cancer, Diabetes)

_____

_____

List any and all surgery/procedures you have had. Please provide dates as well if known.

_____

_____

FAMILY HISTORY

Circle any illnesses in you immediate family(blood relatives),**include how they are related to you.**

Prostate Cancer_____ Bladder Cancer_____ Kidney Cancer_____ Kidney Failure_____ Kidney Stones_____

Breast Cancer_____ Diabetes_____ Heart Problems_____ High Blood Pressure _____ Uterine Cancer_____

Infertility_____ Lung Cancer_____ Skin Cancer_____ Tuberculosis_____ Parkinson's Disease_____

Thyroid Problems_____ Stroke_____ Others_____

SOCIAL HISTORY

Smoking Status: **Current Smoker**: Packs:____ How Long:____ **Former Smoker:**____ When stopped:_____

Never Smoked:____ **Chew Tobacco:**____Yes____No____ **Recreational Drugs:**____Yes ____No ____Type ___

Have you ever had a blood transfusion:____ Yes ____ No

Do you drink Alcohol:____Yes ____ No___ Never Drank _____

Types Alcohol Consumed: Beer Wine Liquore Drinking Habit: Social Light Mod. Heavy

Caffeine (coffee, Tea, Soda, energy drinks): _____ Yes _____ NO ____ How many a day:_____

(TURN PAGE OVER TO COMPLETE)

REVIEW OF SYSTEMS (PLEASE CIRCLE ALL THE APPLY)

Constitutional: Fever Unexplained Weight Loss Chills Other:_____

Eyes: Blurry Vision Double Vision Cataracts Other:_____

Ears,Nose,Mouth,Throat: Hearing Loss Nasal Stuffiness Sore Throat Other:_____

Cardiovascular: Chest Pain Swollen Ankles Irregular Heartbeat Other:_____

Respiratory: Shortness of Breath Wheezing Chronic Cough Other:_____

Gastrointestinal: Abdominal Pain Nausea/Vomiting Change in Bowels Others:_____

Genitourinary: Painful Urination Blood in Urine Incontinence Other:_____

Musculoskeletal: Chronic Back pain Chronic Neck pain Sore Muscles Other:_____

Integumentary/Skin: Rash Persistent Itching History of Skin Cancer Other:_____

Endocrine:(FEELING OF) To Tired/Sluggish To Hot/Cold Excessive Thirst Other:_____

Neurological: Numbness/Tingling Dizziness Tremors Others:_____

Hematologic/Lymphatic: Swollen Glands Transfusion History Abnormal Blood Clotting Other:_____