Northeast Indiana Urology, P.C.

PLEASE COMPLETE THIS FORM IN ITS ENTIRETY

PATIENT REGISTRATION FORM

Today's Date:_____

PATIENT INFORMATION

Race: ☐African American ☐American Indian ☐Asian ☐Caucasian ☐Hispanic ☐Other

Name:_____Gender: M or F (circle one)
(Last) (First) (MI)

Date of Birth:_____ Social Security Number:_____

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

Home phone: (____)_____ Work phone: (____)_____

Cell phone: (____)_____ E-mail Address: _____

Student Status: Full or Part Time (circle one) Employer Name:_____

RESPONSIBLE PARTY INFORMATION

☐ Same as Patient

Name:_____Gender: M or F (circle one)
(Last) (First) (MI)

Date of Birth:_____ Social Security Number:_____

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

Home phone: (____)_____ Work phone: (____)_____

Student Status: Full or Part Time (circle one) Employer Name:_____

INSURANCE INFORMATION

Primary Insurance Company Name:_____Phone: (____)_____

Name of Insured:_____Insured DOB_____Relationship to Patient:_____

Insured SSN:_____Employer:_____Phone (____)_____

Insurance ID#_____Group#:_____Prior Authorization needed? Y or N

Secondary Insurance Company Name:_____Phone: (_____)_____

Name of Insured:_____Insured DOB_____Relationship to Patient:_____

Insured SSN:_____Employer:_____Phone: (____)_____

Insurance ID#_____Group#:_____Prior Authorization needed? Y or N

(Please turn page over for additional information)

REFERRING PHYSICIAN INFORMATION

Referring Physician:_____
(first) (last)

Physician Group Name:_____ Phone (____)_____

EMERGENCY CONTACT INFORMATION

Name:_____Gender: M or F (circle one)
(Last) (First) (MI)
Address:_____
(Street) (City) (State) (Zip)
Home phone: (_____)_____ Work phone: (_____)_____

Cell phone: (_____)_____ Relationship_____

SIGNATURE ON FILE

I authorize payment of medical benefits to Northeast Indiana Urology P.C. for services rendered and authorize release of any medical information necessary to process this claim. I also acknowledge responsibility of payment of all medical fees regardless of any insurance I may have. If for any reasons the account should become delinquent, I agree to pay for all collection and legal fees.

Signature:_____Date:_____

NEW PATIENT HISTORY

NOTE: THIS IS A CONFIDENTIAL RECORD AND WILL BE KEPT IN YOUR DOCTOR'S OFFICE. INFORMATION CONTAINED HERE WILL NOT BE RELEASED TO ANYONE WITHOUT YOUR AUTHORIZATION TO DO SO.

NAME:_____ AGE:_____ TODAY'S DATE:_____

REFERRING DOCTOR:_____ FAMILY DOCTOR:_____

What problem or symptoms bring you here? _____

_____

_____

_____

How severe are your symptoms? _____ *(Rank from 0 = no symptoms to 10 = very severe symptoms)*

What is the duration of your symptoms?_____

Does anything make your symptoms better or worse? ☐ No ☐ Yes, please describe _____

_____

Do you have any of the symptoms listed below? (Check all that apply)

☐ Pain or burning with urination?
☐ Visible blood in urine at any time?
☐ Slow urinary stream?
☐ Difficulty starting urination?
☐ Inability to hold urine (wet pants)?
☐ Urinating too frequently? (more than 6 times a day)
☐ Awakening at night to urinate more than once?
☐ Bedwetting?
☐ Kidney or Bladder infections?
☐ Kidney Stone?
☐ Have you been to a urologist before?
☐ Do you have a decrease in libido? (sex drive)
☐ Do you have a lack of energy?
☐ Do you have a decrease in strength and /or endurance?
☐ Are you sad and/or grumpy?
☐ Have you noticed a decreased enjoyment of life?
☐ Are your erections less strong?
☐ During sexual intercourse, has it been more difficult to maintain your erection to completion of intercourse?
☐ Have you had kidney or bladder x-rays before?
☐ Have you had prior surgery on your bladder or kidneys?

REVIEW OF SYSTEMS: *(please circle Yes or No for each)*

Constitutional			**Psychiatric**		
Fevers	Yes	No	Anxiety	Yes	No
Weight Loss	Yes	No	Depression	Yes	No
Eyes			**Hematologic/Lymphatic**		
Loss of Vision	Yes	No	Bleeding or bruising tendency	Yes	No
			Anemia	Yes	No
Cardiovascular					
Shortness of breath	Yes	No	**Neurological**		
Chest Pain at rest	Yes	No	Headaches	Yes	No
			Seizures	Yes	No
Respiratory					
Chronic or Frequent Cough	Yes	No	**Integumentary**		
Coughing up Blood	Yes	No	Rashes	Yes	No
Gastrointestinal			**Musculoskeletal**		
Vomiting	Yes	No	New Bone Pain	Yes	No
Blood in Stools	Yes	No	Muscle Weakness	Yes	No

Do you have a living will? Yes No

CONTINUE TO NEXT PAGE

OFFICE USE
Physician Initials:

PHARMACIES: Local _____ street/ town _____ Mail Order:_____

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PAST, FAMILY AND SOCIAL HISTORY:

Do you take aspirin or any blood thinners? ☐ No ☐ Yes, please mark which one:

☐ Lovenox ☐ Effient ☐ Coumadin ☐ ASA ☐ Palvix ☐ Pradaxa ☐ Heparin ☐ Persantine

List ALL medications, drugs or pills that you have taken in the last ten (10) days, including over the counter & vitamins.

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

List all medicines you are allergic to or cannot take:

1. _____ 3. _____
2. _____ 4. _____

List all previous operations or surgeries:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

List previous serious illnesses and injuries. Also list ongoing medical problems for which you see a physician.

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

FOR WOMEN ONLY:

Number of Pregnancies: _____

Number of Deliveries: _____

IMMUNIZATIONS: Check off any vaccinations you have had.

☐ Pneumo vax _____ (date, if known)

☐ Influenza (flu shot) _____(date, if known)

FOR WOMEN ONLY.

Date of last Mammogram: _____

*Date of last Pap Smear:*_____

DATE OF LAST COLONOSCOPY: _____ ☐ I've never had a colonoscopy.

FAMILY HISTORY:

Check all that apply

DISEASE	Mother	Father	Sister	Brother	Mom's mother	Mom's Father	Dad's mother	Dad's father
Arthritis								
Heart Disease								
Hypertension								
Diabetes								
Breast Cancer								
Colon Cancer								
Prostate Cancer								
Kidney Stone								

MARITAL STATUS: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

TOBACCO USE: Do you smoke cigarettes?

☐ Never

☐ Not anymore → How many years did you smoke? ____ How many packs/day? _____ Quit date _____

☐ Yes. → How many years have you smoked? _____ How many packs/day? _____

Other Tobacco use? ☐ None ☐ Pipe ☐ Cigar ☐ Snuff ☐ Chew

ALCOHOL USE: Do you drink alcohol? ☐ No ☐ Yes - What Type? ☐ beer ☐ wine ☐ liquor → # of drinks/week? ___

OFFICE USE
Physician Initials:

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AUA SYMPTOM INDEX

Directions: For each question, mark an "X" over the one number that best describes your situation.

	not at all	less than 1 time in 5	less than half the time	about half the time	more than half the time	almost always
1. Over the past month or so, how often have you had a sensation of not emptying your bladder completely after you finished urinating?	0	1	2	3	4	5
2. Over the past month or so, how often have you had to urinate again less than two hours after you finished urinating?	0	1	2	3	4	5
3. Over the past month or so, how often have you found you stopped and started again several times when you urinated?	0	1	2	3	4	5
4. Over the past month or so, how often have you found it difficult to postpone urination?	0	1	2	3	4	5
5. Over the past month or so, how often have you had a weak urinary stream?	0	1	2	3	4	5
6. Over the past month or so, how often have you had to push or strain to begin urination?	0	1	2	3	4	5

7. Over the past month, how many times each night did you most typically get up to urinate from the time you went to bed at night until the time you got up in the morning?

0 none 1 1 time 2 2 times 3 3 times 4 4 times 5 5 or more times

TOTAL AUA SCORE _____

DATE:_____ SIGNATURE:_____

Office Use

Physician Initials

Northeast Indiana Urology, P.C. Assignment of Benefits and Financial Responsibility Form

1. I hereby assign to Northeast Indiana Urology, P.C. (NEIU) any insurance or other third-party benefits available for health care services provided to me. I understand that NEIU has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to NEIU, I agree to forward to NEIU all health insurance and other third-party payments that I receive for services rendered to me immediately upon receipt.

2. I understand that I am responsible for the payment in full of all services rendered by NEIU, subject to any limitations set forth in any applicable insurance or other third party benefits contract.

3. I agree that I will pay all applicable insurance or other third-party benefits, copayments, deductibles, and outstanding balances for which I am responsible at the time of service.

4. I understand that the billing department of NEIU will file all applicable claims for services rendered to my insurance or other third –party benefits carrier. I agree to provide NEIU at the time of service with information required by NEIU to bill my insurance or other third-party benefits carrier including my name, address, insurance or other third-party benefits card, and driver's license. I agree to notify NEIU at every visit of any change in my employment, insurance or other third-party benefits, address, or phone number. After the service is rendered I agree to work with the NEIU billing department and my insurance or other third-party benefits carrier to timely provide any information needed by NEIU or my insurance or other third-party benefits carrier to process my claim.

5. I understand that I am responsible for any services which my insurance or other third-party benefits plan determines are not covered by the plan, out-of-network fees, and for any other amounts which are due and are not required to be written off by the contract (if any) NEIU has with my insurance or other third-party benefits carrier. I agree to pay any such amount in full to NEIU within 30 days of being notified by NEIU of the balance due.

6. If I have questions about my bill and payment responsibility, I agree to immediately contact the NEIU billing department at 260-436-6667 Ext. 284.

7. I understand that failure to pay my balance may result in my account being turned to a collection agency and/or being terminated from the practice. You agree to reimburse us the fees of any collection agency, which may be based on a percentage at a maximum of 33% of the debt, and all costs and expenses, including reasonable attorneys' fees we incur in such collection efforts.

8. In the event that I pay by check and the check is returned due to non-sufficient funds, I agree to pay NEIU a processing fee of $25.00 in addition to my account balance I have for services rendered.

9. If I am rescheduling a vasectomy after having been a "no show" for a previously scheduled vasectomy, I understand that NEIU requires a $150 cancellation fee deposit to be paid in advance, or an appointment will not be rescheduled for me. I agree to pay the $150 cancellation fee deposit, and I understand that if I do not show up for my rescheduled appointment, NEIU will cash the $150 cancellation fee deposit as payment for the holding and processing cost of the "no show" procedure. I understand that if I keep my vasectomy appointment as scheduled, the cancellation fee deposit will be applied to my out-of-pocket expenses for the procedure (such as insurance copay or deductible) and any amount owing to me after my insurance has paid will be refunded to me.

10. If I am unable to pay my bill in full, I may contact NEIU billing department at 260-436-6667 Ext. 284 to determine if I qualify for financial hardship assistance.

11. If I do not have any health insurance I may qualify for a discount based upon the procedure/service. Payment within 30 days is required. Contact the NEIU billing department for details

12. NEIU offers a pre-paid discounted fee for vasectomy procedures to patients without insurance. Patients with insurance must pay any estimated out of pocket cost prior to the vasectomy procedure.

I certify that I understand and agree to comply with the financial responsibilities listed on this form. I further certify that I have received a copy of the Northeast Indiana Urology P.C. Patient Payment Policy.

_____
Printed Name of Patient or Responsible Party

_____ _____
Signature of Patient or Responsible Party Date

July 31, 2004
March 5, 2008
April 13, 2012
April 16, 2014
May 19, 2015
NEIU29

Northeast Indiana Urology, P.C. Patient Payment Policy

Thank you for choosing our practice for your urology needs! We are committed to your satisfaction and providing high quality medical care and treatment. Please understand that your understanding and adherence to our policies will assist us greatly in your treatment and care.

For your convenience, we have answered a variety of commonly asked financial policy questions below.

How May I Pay?
We accept payment by cash, check, VISA and Mastercard.

Do I Need A Referral?
Most of our patients are referred by other physicians or care providers to address specific urological needs. If you have been referred to our practice by another physician, please be sure to provide the name of the referring physician to our front desk staff.

If you have not been referred to our practice by another physician, your insurance carrier may require a referral authorization from your primary care physician in order to pay for your service. Please contact your insurance plan or read your insurance benefits to determine if your plan requires a referral authorization. Although our practice will be happy to care for you without a referral from your primary care physician, you may be responsible for any accounts due which are not covered by your insurance carrier.

What is My Financial Responsibility for Services?
Your level of financial responsibility for services rendered depends on a variety of factors related to the type of insurance coverage you have. Regardless of the type of insurance coverage you have, you are ultimately responsible for payment in full of all charges. Unless you qualify for prompt payment discount or financial assistance, our practice cannot write off your charges. Please contact your insurance carrier if you have any questions regarding your insurance coverage.

When is Payment Due for Services?
You are required to pay all applicable copayments at the time of service. In addition, you should pay any co-insurance, insurance deductible and outstanding balances that are your responsibility at the time of service. Once your insurance carrier has responded to the claim we filed for your services, you will be billed for any amount due. You are responsible to pay this amount in full within 30 days of the date on the bill. Patients are expected to have paid outstanding balances in order to remain a patient of NEIU.

What is My Responsibility for Filing a Claim with My Insurance Carrier?
NEIU will file all applicable claims for services rendered to your insurance carrier. In order to do this, NEIU requires you to provide our practice with your name, your employer, and the name of the responsible party for your account, your address, and your insurance card. You are responsible to notify NEIU at each visit of any change in your employment, insurance, address, or phone number. You are also responsible to work with the NEIU billing department and your insurance carrier to timely provide any information needed by NEIU or your insurance carrier to process your claim.

Does NEIU Have Discounts Available?
NEIU has two types of discounts. The first is a discount for financial hardship. If you cannot pay your bill due to financial hardship, contact our billing department. The billing department will request information from you, which will enable them to determine if you qualify for a financial hardship discount.

The second type of discount is for patients who do not have any insurance coverage, and is based upon the procedure/service and requires payment within 30 days. If you would like to see if you are eligible for a discount, please contact our billing department.

Who is Responsible for Collection Fees?
Failure to pay your account balance in full within 60 days may result in your account being turned to a collection agency. If your account is placed with a collection agency, you will be responsible to pay for all collection fees incurred in obtaining payment of your account balance.

Does NEIU Charge a Fee for Checks Drawn on Accounts with Non-Sufficient Funds?
NEIU charges a processing fee of $25.00 when a check is returned due to non-sufficient funds.

What is the NEIU Financial Responsibility Form?
NEIU requires that our patients sign a Financial Responsibility form prior to treatment for non-emergency services. The NEIU Financial Responsibility form is signed by the patient or their responsible party to indicate their agreement to abide by the patient payment policies of NEIU. Services will not be provided without this form being signed.

Who can I contact for Billing Questions?
Please contact our billing department for any billing questions or additional information regarding NEIU financial policies. For out-of-town patients, call toll-free at (800) 898-0976. Local patients should call (260) 436-6667 Ext. 284.

Appointment Cancellations:
If you are unable to keep your scheduled appointment, please notify the NEIU scheduling department by calling 260-436-6667 option 1, 24 hours or as far as possible in advance. Failure to keep your appointment without notification is considered a "No Show". Patients may be terminated from the practice after a combination of 3 consecutive no shows or cancellations with 30 days notice.

Advanced Practitioner Providers:
NEIU has 8 board certified physicians, 3 nurse practitioners and 1 physician assistant to meet your urology needs. Our nurse practitioners are highly skilled and are licensed as independent practitioners with the ability to prescribe medication and perform procedures. Whether you are scheduled to see a nurse practitioner or physician depends on availability and other factors, but in either case you will receive high quality care. Sometimes the provider you are scheduled to see will change due to unexpected emergencies or other circumstances. In order to avoid long delays with your scheduled appointment time, you may be required to see a nurse practitioner.

Pre-Authorization/Certification:
Many insurance companies require pre-authorization for some procedures or services. NEIU obtains pre-authorizations on some of our higher charge services such as outpatient surgery, CT procedure, radiation therapy and others. Regardless of whether NEIU obtains pre-authorization, payment for service is still the responsibility of the patient.

Ancillary Services:
In addition to the services provided by NEIU physicians, nurse practitioners and nurses, you may receive bills for services that are ordered as part of your overall examination but are performed by other providers. Most often, this would include pathology testing that is sent out or that is interpreted by the pathology group at NEIU.

Patient Signature:_____Date:_____

2512 E. Dupont Rd., Suite 100 ■ Fort Wayne, Indiana 46825 ■ 260.436.6667 ■ Fax: 260.469.7437

Rudolph Bowens, Jr., MD ■ John B. Brinkman, MD ■ Mark D. Dabagia, MD ■ Christopher King, MD ■ George Martin, MD ■ Thomas Nill, MD ■ David Pollifrone, MD
Gita Singh, MD ■ A. Craig Thomas, MD ■ Theodore T. Wagner III, MD ■ Sarah Bishop, NP-C ■ Sarah Brady, NP-C ■ Chelsea Handshoe, NP-C ■ Tracy Mullins, FNP-BC

NOTICE OF FINANCIAL INTEREST IN HEALTH CARE ENTITY

The undersigned individual is hereby notified that the physicians associated with Northeast Indiana Urology. P.C. (Dr. Brinkman, Dr. Dabagia, Dr. Martin, Dr. Nill, Dr. Pollifrone, Dr. Thomas and Dr. Wagner) (collectively the "Physicians") are each part-owners of and have a financial interest in Dupont Hospital, LLC (the "Hospital"), and Dr. Dabagia (collectively the "Physician") is a part-owner and have a financial interest in Lutheran Hospital (the "Hospital") and (Dr. Brinkman, Dr. Dabagia, Dr. Martin, Dr. Nill, Dr. Pollifrone, Dr. Thomas and Dr. Wagner) (collectively the "Physicians") are each part-owners and have a financial interest in NEIU Prostate Cancer Center ("Cancer Center") and Dr. Brinkman, Dr. Dabagia, Dr. Martin, Dr. Nill, Dr. Polilfrone, Dr. Thomas and Dr. Wagner (collectively the "Physicians") are each part-owners and have a financial interest in lithotripsy services at Dupont Hospital, Lutheran Hospital and Premier Surgery Center (the "Hospitals"). The Physicians believe the Hospital and Cancer Center are each an appropriate setting for the medical care and services for which the undersigned is being referred. Nevertheless, the selection of a specific health care entity/facility always rests with the patient, and as such, the undersigned may choose to be referred to an alternate entity/facility of his/her choice.

Patients may choose to obtain their CT service at another facility. CT services are available in the following locations:

- The Imaging Center, 6731 West Jefferson Blvd, Fort Wayne (260) 436-7770
- For patients who would like a facility outside of Fort Wayne, all hospitals have CT services.
- If you need assistance locating a facility for your CT service, please contact us at 260-489-5335.

The undersigned hereby acknowledges and certifies that he/she has received a copy of the Notice of Financial Interest in Health Care Entity.

Date:_____
Signature of Individual:_____
Printed Name of Individual:_____

If the individual is unable to make written acknowledgement because of age or physical condition, complete the following:

Individual is: a minor, _____ years of age; or (state the reason) _____
_____
State relationship to patient: _____
Date:_____
Signature of Representative/Legal Guardian:_____
Printed Name of Representative/Legal Guardian:_____

WELLNESS CARE vs PROBLEM-ORIENTED CARE

Dear Patient:

Thank you for choosing Northeast Indiana Urology, PC for your medical needs. We value our relationship with you and appreciate the opportunity to serve your medical needs.

If you are presenting for a “wellness” visit, it is important to understand there are specific regulatory guidelines and rules with each insurance carrier that control when a physician can appropriately submit a bill to your insurance carrier for “wellness” or “preventative” services.

A wellness visit is defined as a visit that has no known medical problem or complaint being evaluated. This means you cannot have any symptoms, complaints or problems as the reason to see the physician today. If you are presenting with symptoms, complaints, or problems then the visit must be billed as a “problem-oriented” visit.

Also, if your visit qualifies as a wellness visit and an abnormality or a pre-existing problem is addressed in the process of performing this preventive medicine visit, and if the problem/abnormality is significant enough to require additional work in order to appropriately address your medical needs, then a separate service or visit code may be billed in addition to the preventative/wellness service. Alternatively, the physician may decide to treat the specific problem and ask you to schedule another appointment for your wellness visit.

Billing a service as a wellness visit is not an elective decision by the physician and must be made in compliance with government and insurance billing regulations. Your understanding is appreciated. If you have any questions or concerns regarding the classification of wellness or problem-oriented visits, please contact your insurance carrier to discuss the matter or consult your insurance plan documents.

Sincerely,

Northeast Indiana Urology, PC