Urology Center
Of Spartanburg, P.C.

Patient Information

Name: _____ Date of Birth: _____ Sex: M F

Mailing Address: _____ Marital Status: S M D W Other_____

City: _____ State: _____ Zip: _____ Social Security #: _____

Phone: Home: _____ Cell: _____ Work: _____

Race: ( ) White ( ) Black/African American ( ) Hispanic ( ) American Indian ( )Asian ( )Other:_____

Ethnicity: ( ) Hispanic/Latino ( ) Not Hispanic/Latino ( ) Declined

If a minor: Child's Fathers Name: _____ Childs Mother's Name: _____

If the patient is a minor child and the parents are legally separated or divorced please complete the following:
Which parent has legal custody of the minor child? _____
Which parent is financially responsible for the minor child's medical expenses after insurance? _____
Please provide a copy of the legal documentation stating the parent responsible for medical expenses to be included in the patient's medical record.

Guarantor Information

( ) Check here if the guarantor is the same as the patient

Name: _____ Date of Birth: _____

Mailing Address: _____ Social Security #: _____

City: _____ State: _____ Zip: _____ Relation to Patient: _____

Phone: Home: _____ Cell: _____ Work: _____ Preferred Phone: home work cell

Primary Insurance Information:

Name of Primary Insurance: _____

Mailing Address for Claims:_____

Group #: _____ ID: _____ Effective Date: _____

Subscriber Information **( ) Check here if same as the patient**

Name: _____ Date of Birth: _____ Social Security #: _____

Mailing Address: _____ Phone:_____

City: _____ State: _____ Zip: _____ Relation to Patient: _____

Secondary Insurance Information:

Name of Primary Insurance: _____

Mailing Address for Claims:_____

Group #: _____ ID: _____ Effective Date: _____

Subscriber Information **( ) Check here if same as the patient**

Name: _____ Date of Birth: _____ Social Security #: _____

Mailing Address: _____ Phone:_____

City: _____ State: _____ Zip: _____ Relation to Patient: _____

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

Date of Birth: _____ **Social Security Number:** _____

Height: _____ **Weight:** _____ **(lbs)**

Pharmacy Name: _____ **Location:** _____ **Phone #:**_____

Allergies to Medications: _____

Current Medications: Please list any prescription medications, over the counter medications, and vitamin supplements you take routinely: Check None if you are not taking any medications □ **None**

Name of Drug / Supplement:	Strength (mg)	How often (# of times per day):

Surgical History – List all prior surgeries and dates (approximate):

_____

_____

_____

_____

Medical History – Check all that apply to you:

□ Anemia
□ Asthma
□ Arthritis
□ Cancer:
Type: _____
□ CVA (Stroke)
□ Chronic UTI
□ COPD
□ Elevated PSA
□ Chronic Kidney Dis
□ Deep Vein Thrombosis
□ Depression
□ Diabetes
□ GERD
□ Gout
□ Hepatitis C
□ High Cholesterol
□ Hyperlipidemia
□ Low Testosterone
□ High Blood Pressure
□ Heart Disease
□ Heart Attack
□ IBS
□ Lupus
□ Liver Disease
□ Migraine Headaches
□ Anxiety
□ Osteoarthritis
□ Atrial Fibrillation
□ Osteoporosis
□ Parkinson's
□ Peripheral Vascular Dis
□ Rheumatoid Arthritis
□ Seizures
□ Thyroid Disease
□ Kidney Stones
□ Valvular Heart Disease
□ Traumatic Brain Injury
□ Obesity

List any other medical conditions / diagnosis / disease here:

_____

_____

_____

CONTINUED ON BACK →

Family History: Check any illness in your immediate family and include relationship – (Blood Relatives Only)

Diagnosis	Relationship	Diagnosis	Relationship
____ Bladder Cancer		____ Kidney Failure	
____ Breast Cancer		____ Kidney Stones	
____Diabetes		____ Lung Cancer	
____ High Blood Pressure		____ Prostate Cancer	
____ Kidney Cancer		____ Stroke	
Other:			

Social History:

1. **Marital Status:** □ Married □ Single □ Divorced □ Widowed □ Separated

2. **Smoking Status:**

□ Never Smoker □ Former Smoker □ Current Every Day Smoker □ Current Some Day Smoker

- **If current or former smoker:**

How much do/did you smoke per day? _____

How many years did/have you smoked? _____

3. **Do you drink alcohol?** **Yes** **Not anymore** **Never**

Type of Alcohol: **Beer** **Wine** **Other**

Drinking Habit: **Social** **Light** **Moderate** **Excessive**

4. **How many caffeinated drinks do you have each day?** □ 0 □ 1 □ 2 □ 3 □ 4 +

5. **Have you ever had a blood transfusion?** □ Yes □ No

6. **Language:**

□ English □ Spanish □ French □ German □ Portuguese □ Russian □ Chinese □ Other: _____

7. **Race:**

□ White □ Black/African American □ Hispanic □ Asian □ American Indian/Alaska Native □ Eskimo □ Pacific Islander □Unknown

Review of Systems: (Circle all that apply)

Constitutional:	Fever	Chills	Weight Loss	Other: _____
Eyes:	Blurry Vision	Double Vision	Cataracts	Other: _____
ENT and Mouth:	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	Other: _____
Genitourinary:	Incontinence	Painful Urination	Blood in Urine	Other: _____
Musculoskeletal:	Chronic Back Pain	Chronic Neck Pain	Sore Muscles	Other: _____
Integumentary/Skin:	Rash	Persistent Itching	Skin Cancer History	Other: _____
Neurological:	Numbness	Tingling	Dizziness	Other: _____
Hematologic/Lymphatic	Swollen Glands	Abnormal Bleeding	Transfusion History	Other: _____

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General Consent to Treat and
Patient Acknowledgement of Privacy Practices Notice

You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).
This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended at any of our practicing locations. You have the right at any time to discontinue services. The consent will remain fully effective until it is revoked in writing.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks, and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or their designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I may be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have received a copy of the Notice of Privacy Practices. This notice describes how my health information may be used or disclosed. I understand that I should read it carefully. I am aware that the Notice may be changed at any time. The Notice of Privacy Practices may be accessed at www.urologycenter.net.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____	_____
Signature of Patient or Personal Representative	**Date**
_____	_____
Printed Name of Patient or Personal Representative	**Relationship to Patient**
_____	_____
Printed Name of Witness	**Date**
_____	
Signature of Witness	

Urology Center
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Financial Policy

We are excited that you have chosen to put your trust into our practice for your healthcare needs. We are committed to helping to provide the best medical care possible for you. We hope that you will take a moment to familiarize yourself with our financial policies.

Patient Information

Providing our office with the most accurate information at the time of service helps to make sure that your claims are filed correctly to your insurance company.

1. We ask that you present your insurance cards and picture ID at every visit. It is your responsibility as the patient to provide our office with the correct information to bill your insurance.
2. If you have a change of address or telephone number, or any information that could delay insurance payments, please notify our front office.

Referrals and Authorizations

While Urology Center of Spartanburg does not require a referral from your primary care physician for you to be seen or treated, your insurance plan may. Obtaining this referral is your responsibility. Failure to obtain this referral may mean that your insurance company will not pay benefits for your visit. Please remember to check with your insurance company to determine their requirements. If your plan requires **you** to have an authorization to see a specialist, **you** will need to obtain that from your Primary Care Physician prior to seeing the specialist. If authorization is not obtained, **you** will be held responsible for the balance for that date of service.

Copays, Deductibles, and Co-insurance

Payment is required at the time services are rendered unless other arrangements have been made in advance. This includes applicable coinsurance and copayments for participating insurance companies. Please remember that patient responsibility amounts are determined by your individual insurance plan, not Urology Center of Spartanburg. For your convenience we accept cash, personal checks, Visa, MasterCard, American Express, Discover, and Care Credit. There is a $30.00 charge for returned checks.

Past Due Balances

If your insurance company denies our charges, you will be responsible for the entire balance. You are expected to pay your balance within 30 days of the insurance denial. If you need to make arrangements, you may speak with our Business Office. Patients with an outstanding balance of 60 days or more must make arrangements for payment prior to scheduling further appointments. The Urology Center of Spartanburg reserves the right to advise you to seek care through an alternate clinic or medical provider if your account becomes delinquent.

Self-Pay Patients

Patients without insurance or patients who waive the right to have their insurance filed are expected to make payment in full at time of visit. New patients will be responsible for a deposit of $250.00 at check-in. Established patients will be responsible for a deposit of $90.00 at check-in. You will be responsible for the remainder of the balance at check-out.

I acknowledge that I have read and have had the opportunity to ask any questions regarding Urology Center of Spartanburg's Financial Policy. I agree to assign insurance benefits to the Urology Center of Spartanburg for all services provided. I also agree to be responsible for an administrative collections fee and/or any additional fees charged by a collection agency or court fees and costs associated with collections of this debt, along with the original debt.

Signature of patient or
Authorized representative: _____ Date: _____

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No Show/Late Cancellation Policy

We understand that appointments are missed occasionally for a variety of reasons. Appointments that are not cancelled within 24 hours before you are scheduled to arrive are very difficult for our staff to fill, thus you could be hindering another patient from receiving much needed medical treatment.

Please read our policy carefully and sign the bottom stating that you agree to abide by this policy:

1. If you are unable to keep your appointment, we require that you cancel 24 hours in advance. You may cancel or reschedule your appointment by calling (864) 585-8221.

2. If you fail to cancel your appointment within 24 hours, you will be subject to the following charges:
   - Established Patients: $25
   - New Patients: $50
   - Radiology: $50
   - Urodynamics: $100
   - BCG/Lupron Treatments/Other Treatments: $75

3. These fees are required to be paid before you can be seen at your next scheduled appointment. (No Show/Cancellation fees cannot be billed to your insurance and are the responsibility of the patient.)

4. Repeated no shows or late cancellations may result in you being discharged from the practice. If you are discharged from our practice, we will provide emergent care only for 30 days while you establish care with another practice.

_____
Patient Name (Print)

_____ _____
Patient Signature Date

Compound Authorization for Treatment and Social Media

Patient Name: _____
Social Security Number:_____ **DOB:** _____
Address: _____
City/State/Zip: _____

This authorization form permits:

The Urology Center of Spartanburg, PC
391 Serpentine Drive
Spartanburg, SC 29303

to use or disclose protected health information to the entities or people listed below for the above named patient:

Authorization to leave voicemail:
Indicate which voicemail boxes, if any, and type of information we may leave:

Home #:_____ ☐ Appointments/Test Results ☐ Financial information
Cell #:_____ ☐ Appointments/Test Results ☐ Financial information
Work #:_____ ☐ Appointments/Test Results ☐ Financial information

Authorization for Email and Text Messaging:

Email: _____
☐ Appointment ☐ Financial information ☐ Medical /Treatment information

Text Messages: Phone #: _____
☐ Appointment ☐ Financial information ☐ Medical /Treatment information

School / Work
Indicate if your School or Work may receive information about your appointment:

School Name_____ ☐ Appointment Dates
☐ Return to School Date
Workplace_____ _____ ☐ Return to Work Date

Both Biological parents of minors are entitled to receive all information unless a court order indicates otherwise and is submitted to our office.

Others who may receive information: (Ex. Parents, Spouse, Step-Parents, Grandparents, Childcare, etc)

Name:_____ Relationship:_____
☐ Appointment ☐ Financial information ☐ Medical /Treatment information

Name:_____ Relationship:_____
☐ Appointment ☐ Financial information ☐ Medical /Treatment information

Name:_____ Relationship:_____
☐ Appointment ☐ Financial information ☐ Medical /Treatment information

Authorization for general viewing or social media viewing of patient name:
☐ Contest Information ☐ Photos: Office placement ☐ Photos: Social Media placement

***** Please read and sign the next page to authorize these disclosures**.

Purpose
The purpose of this authorization is to meet the patient's request for information disclosures and uses.

Expiration date or event: This authorization shall be enforced until revoked by the patient in writing or the patient leaves the practice.

Verification method or code: This practice will verify the identity of any entity requesting protected health information. Verification information may include, but is not limited to, driver's license or photo ID.

Rights of the Patient
I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

I understand that I have the right to revoke this authorization at any time by sending a written notification to the address listed at the top of this form I understand that a revocation is not effective in cases where the information has already been used or disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

_____ _____
Signature of Patient or Personal Representative (as defined by HIPAA) Date

Description of Personal Representative's Authority (attach necessary documentation)

_____

****

Office Use Only:

Receiving Employee_____ Date received_____

☐ Copy given to patient