Mohamed & Associate's Urology Center, PA
507 North Brightleaf Blvd, Ste. 205
Smithfield, NC 27577
Phone (919)934-5955 Fax (919)934-0959

Dear Patient,

It is with the greatest pleasure that we welcome you to our Urology Practice.

For your convenience, we have enclosed a health questionnaire and other information. If you have any questions, feel free to call us at (919)934-5955.

Please bring the enclosed forms completed and filled out with you to your scheduled appointment, along with your insurance information, Picture ID and any medications you currently take on a daily basis.

We look forward to meeting you and serving your urology needs now and in the future.

Mohamed & Associate's Urology Center, PA

Patient Information

Social Security Number ______________________________

Name ______________________________

Address ______________________________

Town ____________________ State ________ Zip ____________

Age ________ Date of Birth ____________ Driver License # ______________

Home Phone ________________ Cell Phone ______________ Language ____________

E-Mail ______________________________ Race ________

Employer ______________________________ Ethnicity __________

Address ______________________________ Phone ____________________

Spouse ____________________________ Date of Birth ____________________

Spouse's Employer ________________________ Phone ____________________

Primary Physician ______________________ Phone ____________________

Emergency Contact ______________________ Phone ____________________

Referred by : __________________________ Phone ____________________

Pharmacy Name __________________________ Phone ____________________

Pharmacy Location ______________________ How did you hear about us? ____________________

If patient is a minor, please list parent's information:

Father ____________________________ Mother ______________________

Employer/Phone ____________________ Employer/Phone ______________

______________________________ ________________

Signature Date

What is your preference of contact: land line e mail cell number

We accept most insurances, Mastercard, Visa and Care Credit. * Have insurance cards available*

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Mohamed & Associates Urology Center participates with most insurance carriers and one of the services that we provide to take care of billing the insurance company for you. However, we cannot always predetermine what the insurance company will pay or what will be "patient" responsibility. In an effort to minimize any financial surprises to you, we ask that you please read and initial all the following:

______ I will pay my copay at the time of service for EACH visit.

______ I agree to pay any balance due on my bill after my insurance has paid all they are going to pay.

______ I understand that providing correct insurance information is my responsibility.

______ I understand that paying for services is my responsibility, regardless of insurance.

PRINT full name of patient	Signature	Date

*Please not Mohamed & Associates Urology will make every effort to communicate with you in regards to any unpaid balances. We have a billing specialist on hand to work with our patients to make payment arrangements that are comfortable for any size balance. We will send out statements of balance, collection letters, and will attempt to reach you at all phone numbers we have on file. If you would like to make an arrangement to pay your balance, please call the office and we will be happy to work with you.

Thank you!

HIPPA AND FINANCIAL POLICY

Insurance Policies:
We will, as a courtesy, file insurance claims on you behalf. Please note that if your insurance company fails to pay within a timely manner it will become your responsibility. Secondary claims will be filed once we receive primary insurance payment.

All co-pays are due at the time of service.

All outstanding balances and deductibles are due at the time of service.

Self Pay:
If you are a self pay patient, you will have to pay the entire bill at the time of service

Medical Records/Disability/FMLA
There will be a $10.00 charge for any medical forms that we complete for you. This charge is for each form completed. This will have to be paid at the time the papers are dropped off to be completed. You must allow at least 7 – 10 business days for the forms to be completed.

HIPPA:
Due to the Health Insurance Portability and Accountability Act we will not disclose your PHI (Protected Health Information) to anyone other than; yourself, coordinating care providers, hospitals and your insurance carrier. This may be done by mail, phone or fax. Name anyone else you want to have access to your information below. (This would allow us to leave a message regarding your PHI with a designated individual.)

I consent____to access my PHI.

I understand that I am responsible for all non-covered services and payment of charges is due at the time of service. I hereby give consent to Mohamed & Lippitt Urology Center to provide whatever treatment the assigned physician/provider may deem medically necessary on my behalf. I release my insurance benefits to be paid directly to Mohamed & Lippitt Urology Center. I have read and acknowledge this financial policy.

Signed:_________________________________ Date:__________________________

A. Notifier: **MOHAMED AND ASSOCIATES UROLOGY CENTER**

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Non coverage (ABN)

NOTE: If Medicare doesn't pay for **D.SERVICE/PROCEDURE/CARE/EQUIPMENT** below, you may have to pay.Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D. SERVICE/PROCEDURE/CARE/EQUIPMENT** below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
SERVICE/PROCEDURE/CARE/EQUIPMENT	MEDICARE DOES NOT PAY THIS SERVICE/PROCEDURE/CARE FOR YOUR CONDITION, IF PERFORMED TO FREQUENTLY OR IT IS CONSIDERED EXPERIMENTAL OR RESEARCH. MEDICARE DOES NOT REIMBURSE THIS FACILITY FOR MEDICAL SUPPLIES SUCH AS, CATHETERS, LEG BAGS, ETC...	Estimate of $10.00 to $10,000.00

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the
- **D. SERVICE/PROCEDURE/CARE/EQUIPMENT** listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: **Check only one box. We cannot choose a box for you.**

☐ **OPTION 1.** I want the **D. SERVICE/PROCEDURE/CARE/EQUIPMENT** listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D. SERVICE/PROCEDURE/CARE/EQUIPMENT** listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

☐ **OPTION 3.** I don't want the **D SERVICE/PROCEDURE/CARE/EQUIPMENT**.listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

Mohamed and Associates Urology Center

Chart # __________

Today's Date ______________

Patient History Form

Please complete the following questions about your medical history. Thank you.

Name:		Date of Birth:
Why are you seeking treatment today?		
Who is your referring physician?	Primary Care Physician?	
Are you in pain?	What is the intensity of your pain? 1 (No pain) – 10 (Most Severe) 1 2 3 4 5 6 7 8 9 10	
List any allergies	Reaction to each allergy	
Please have an updated medication list available upon arrival.		
Medical and Social Information:		
Date of last influenza vaccine:	Date of last pneumococcal vaccine:	
Date of last colonoscopy:		
Date of last mammogram for females:		
Marital Status: Single Married Divorced Widowed	Number of biological children:	
Where do you currently live? At home In a nursing home Alone		
Do you have a living will?	If yes, what is the name of the surrogate?	
Occupation: Full-time Part-time Retired		
Do you currently smoke?	How much?	
Former smoker?	When did you quit?	
Do you use alcohol? Occasionally Rarely		
Do you wear glasses?	Do you wear contact lens?	
Do you wear dentures? Full Upper Lower		
Do you use ambulatory assistance? Wheelchair Walker Cane		
Name and location of your pharmacy:		

Medical History: Circle all that apply	**Past Surgeries: Circle all that apply and <u>indicate date</u>**	**Recent Symptoms: Circle all that apply**
COPD	Kidney Surgery	Frequent Urination
Heart Disease	Lithotripsy	Night time Urination
Pacemaker	Kidney Stone Surgery	Burning on Urination
Defibrillator	Bladder Surgery	Blood in Urine
Lung Disease	Cystocele Repair (Dropped Bladder)	Blood in Semen
Diabetes	Bladder Tumor Removal	Testicular Pain
High Blood Pressure	Prostate Biopsy	Groin Pain
Bowel Problems	Radical Prostatectomy	Back Pain
Stroke/Seizures	Transurethral Resection of Prostate	Side Pain
Kidney Problems	Joint Replacement	Slow Stream
Bleeding Disorders	Open Heart Surgery	Bladder Leakage
HIV/AIDS	Heart Valve Surgery	Bedwetting
Hepatitis A Hepatitis B Hepatitis C	Heart Stents	Scrotal Swelling
Cancer Type:	Colon Surgery	Vaginal Bleeding
Psychiatric Problems	Gall Bladder Surgery	Vaginal Discharge
Coronary Artery Disease(CAD)	Cataract Surgery	Unable to Urinate
Other:	Hernia Repair	Erectile Dysfunction
Family History: Circle all that apply and <u>indicate which relative</u>. (Parents/siblings/aunts/uncles)	Tubal Ligation	Constipation
	C-Section	Rash
Prostate Cancer	D & C	Other:
Kidney Cancer	Ectopic Pregnancy	**Review of Systems: Circle all that apply**
Kidney Disease	Hysterectomy	Fever
Kidney Stones	Laparoscopy	Unexplained weight loss Blindness
Colon Cancer	Cervical LEEP	Deafness Asthma COPD
Breast Cancer	Ovaries Removed	GERD Indigestion Bloody Stools
Ovarian Cancer	Rectocele Repair	Arthritis Fibromyalgia Skin Lesions
Uterine/Cervical Cancer	Uterine Ablation	Numbness Tremors
Heart Disease	Vaginal Cancer	Thyroid Anemia
High Blood Pressure	Vasectomy	Blood Cancer Autoimmune Problems
Diabetes Other Cancers:	Other Surgeries:	Other: