WEST GEORGIA UROLOGY ASSOCIATES, P.C.
Patient Financial Policy

It is the goal of West Georgia Urology Associates, P.C. ("WGUA") to provide quality medical care to our patients in an effective and pleasant manner. To avoid any confusion or misunderstanding, WGUA provides its patients with information related to your financial obligations and our financial policy and procedures. If you have any questions, please ask the receptionist to assist you.

Please read this document carefully, initial each item, sign and date where indicated.

WGUA files insurance claims as a courtesy and convenience to our patients. You, the patient, remain financially responsible for payment unless your insurer reimburses WGUA for the services pursuant to your insurance policy coverage. In order for WGUA to process your insurance claims, **you must present your current insurance card(s) and one form of photo identification with your current address to the receptionist at each visit in order for us to file a claim with your insurer on your behalf. Inability to provide your insurance and photographic identification documentation will result in your appointment being rescheduled or you will be required to pay all charges for the visit prior to being seen.** If you have more than one insurer, in order for the benefit coverage of your claim to be paid appropriately by your insurers, **you must produce proof of current insurance for each policy and you must indicate to the receptionist which insurance plan is primary and which is secondary**. If you have a change in your insurance company during the course of your treatment, it is your responsibility to timely provide the updated information to us to avoid your insurer's denial of coverage. Any updates of insurance information that are not timely received and result in the insurer's denial of your claims will be invoiced to you and must be paid prior to or at the time of your next appointment.

WGUA is obligated by insurance provider contracts to collect your co-pays and deductibles. **Co-pays and deductibles are collected at check-in before being seen by our providers.**

It is your responsibility to verify your coverage with your insurer prior to your office visit. In the event that your insurer determines a service is "Non-Covered," or "Not a Benefit," you, the patient, will be responsible for all charges.

It is your responsibility to obtain all necessary referrals and to follow your insurer's coverage plan guidelines and practices. **If a referral is required and our office does not receive this at the time of your appointment, we will be forced to reschedule your appointment.** Any discrepancies regarding the referral that are discovered may result in delay or rescheduling of your appointment. Patients may elect to self- pay in cases where discrepancies are discovered, if they so choose.

If WGUA is not a participating physician provider for your insurer carrier, or if you have no insurance, payment in full will be required by you at the time services are rendered. You may request that WGUA's Billing Department send a copy of bill to your insurer. This is done, upon your request, as a courtesy to you. No contractual adjustments to charges will be made by WGUA and payment in full will be required at time of service.

Any patient over the age of 18, or an emancipated minor, will be held financially responsible for all charges incurred. The parent(s) or legal guardian will be financially responsible for patients under the age of 18 years unless they are emancipated. WGUA does not involve its practice in the family or financial matters of its patients. If a court order or decree requires a party to be financially responsible for payment of healthcare services, that party must either be present at the time of service or make advance arrangements for payment.

In the event that after sixty (60) days from the date we file your claim your insurer has not reimbursed WGUA for services rendered or your insurer determines that the charges are the patient's responsibility, you will be mailed a detailed statement. These statements are sent monthly. **If you fail to meet your financial responsibility within sixty (60) days receipt of the statement, your account may be turned over to our collections agency. Patients are responsible for all collection fees, including attorney fees. All collection balances must be paid in full before future appointments can be made. For purposes of determining the date of receipt of the statement, you will be deemed to have received the statement three (3) business days after it is posted by the USPS to the current address you have given to WGUA. It is your responsibility to provide WGUA written notice of any changes to your address.**

Worker's Compensation – A Worker's Compensation authorization of payment form from your employer is required for all work-related visits and must be provided to WGUA upon check-in before being seen by our office. In order for WGUA to file a claim on your behalf for your worker's compensation healthcare benefits, we must receive your employer's authorization of payment. **You are financially liable for all services rendered to you if you fail to timely provide WGUA your employer's authorization of payment for worker's compensation benefits.**

Surgical Prepayment Policy – If your physician determines that surgery is needed, our office will consult with your insurance carrier and prepare an estimate of the charges for the proposed surgery. **West Georgia Urology Associates, P.C. requires that patients pay their portion of the surgical fees *in advance* of the procedure.** Following many surgeries, there is a global period where no professional fee charges are made for follow-up visits. This grace period does not typically include the cost of supplies, labs, or other incidentals. Routinely, any costs that are billed to your insurance will also result in your insurer's determination that a charge for co-insurance is the financial responsibility of the patient. In that event, you will be billed for the co-insurance charges.

Disability and Form Completion Policy - In the event that you have need for Disability Insurance, FMLA or other forms to be filled out by our office, please be aware that although forms are completed as a courtesy to our patients, there is a **minimum charge of $25 per form payable in advance**. Completion of forms *usually* takes seven (7) to ten (10) *business* days for completion, to avoid unnecessary interruption to patient care. **No forms are completed on a rush or emergent basis so please plan accordingly**. If you are a Worker's Compensation patient, Work Comp does not reimburse for the completion of forms. **Forms received without payment will be returned to the patient uncompleted.**

Appointment No Show/Late Cancellation Policy – West Georgia Urology Associates, P.C. schedules appointments based on patient need and physician availability. **Patients need to arrive *30 minutes prior to appointment*, unless informed otherwise by the staff. You must notify our office at least 24 hours in advance if you will be unable to keep a scheduled appointment.** This allows other patients who may have an urgent need the chance to be seen in a timely fashion. Failure to provide timely notice of cancellation or failure to appear on time for your appointment, may result in a "No Show" charge for your appointment. The "No Show" charge for a missed appointment is $25 for a missed office visit and $50 for a missed procedure appointment. Repeat "No Shows" can result in the patient being dismissed from West Georgia Urology Associates, P.C. If you arrive 15 minutes or more late for your appointment, you are deemed a "No Show" for failure to arrive on time. Your appointment may have to be rescheduled to another date and time.

Patients are responsible for all costs related to delinquent accounts and a $30 fee will be assessed for any check returned for insufficient funds. At that time only cash, credit card or money order will be accepted for payment.

Medical Records Requests. In order to comply with HIPAA and Georgia law, and to minimize unnecessary and/or duplicative medical records requests which are costly and burdensome to WGUA, the following procedure and charges will be applied. **The cost of medical records is as follows**: $25.88 for search, retrieval and administrative costs; plus $9.70 for certification of the record (if requested), plus the actual cost of postage (if mailed); plus $0.97 for pages 1-20; $0.83 for pages 21-100; and $0.66 for every page over 100. **Upon receipt of your written HIPAA compliant request for medical records**, WGUA will notify you of the total cost based upon the actual charges to be incurred. When payment of these costs is received, WGUA will release or transmit your record, as directed in compliance with HIPAA and Georgia law.

As a patient you have the right to obtain your medical services from any provider. The physician owners of West Georgia Urology, PC want their patients to know that they have an ownership interest in Horizon Lithotripsy LLC, which provides lithotripsy services at Higgins General Hospital located at 101 Allen Memorial Drive, Bremen, Georgia.

Assignment of Benefits. I authorize assignment and direct payment to **West Georgia Urology Associates, P.C.** any and all payments for medical and/or surgical services rendered to me. I understand that my insurance and/or Medicare may not cover all charges and that I am financially responsible for all charges that exceed or are not covered by my insurance and/or Medicare, including co-pays and deductibles and charges for non-covered services. I acknowledge that I am responsible for reasonable interest, collection fees, attorney fees and/or court costs incurred in connection with any attempt to collect amounts that I may owe to West Georgia Urology Associates, P.C.

By signing below, I acknowledge that I have read and understand the financial terms of West Georgia Urology Associates, P.C.'s Patient Financial Policy. I agree to these terms and accept financial responsibility for all services rendered by WGUA to the patient.

Signature of Patient or Responsible Party	Please Print Patient Name	Date

Print Name of Person Financially Responsible	Relationship of Person to Patient

West Georgia Urology

Patient Medical History Form

Patient Name: _____ **Date:** _____

MEDICAL HISTORY:

Do you have or have you ever had any of the following: Yes or No

Heart disease	Y	N	Who is your heart doctor? _____
Heart attack	Y	N	When? _____
High Blood Pressure	Y	N	
Diabetes	Y	N	
Stroke	Y	N	When? _____
Asthma	Y	N	
Cancer	Y	N	What kind? _____ When? _____
Kidney Stone	Y	N	When? _____
Urinary/Bladder Infection	Y	N	How often? _____
Thyroid Disease	Y	N	
Arthritis	Y	N	
Glaucoma	Y	N	

Other Medical Issues:

_____

_____

PREVIOUS SURGERY:

Circle Yes (Y) or No (N). If yes, indicate Date of Surgery.

Heart Bypass	Y	N	When? _____
Heart Angioplasty	Y	N	When? _____
Heart Stent	Y	N	When? _____
Gallbladder	Y	N	When? _____
Appendix	Y	N	When? _____
C-Section	Y	N	When? _____
Hysterectomy	Y	N	When? _____ Ovaries Still In? Y or N
Tonsils	Y	N	When? _____
Ear Tubes	Y	N	When? _____
Hernia	Y	N	When? _____

Other Surgeries (please list):

_____

_____

FAMILY HISTORY:

Father Living? If yes, Age: _____
Deceased? Cause of Death: _____ Age at Death: _____

Mother Living? If yes, Age: _____
Deceased? Cause of Death: _____ Age at Death: _____

Has any blood relative ever had any of the following? Yes or No

Heart Disease	Y	N	Kidney Stone	Y	N
High Blood Pressure	Y	N	Prostate Cancer	Y	N
Bleeding Disorder	Y	N	Ulcers	Y	N
Tuberculosis	Y	N	Asthma	Y	N
Hepatitis	Y	N	Allergies	Y	N
Stoke	Y	N			
Diabetes	Y	N			
Cancer	Y	N	Who & what kind? _____		

SOCIAL HISTORY:

Chew/Dip Tobacco	Y	N	How Long? _____ Quit? How long: _____
Smoke	Y	N	__Packs/Day for ____Yrs. When Quit?_____
Drink Alcohol	Y	N	Amount? _____ for ___ Yrs. When Quit?_____
Use Drugs	Y	N	

CURRENT MEDICATION / ALLERGY LIST

Patient Name: _____ Date: _____

Date of Birth: _____ Phone: _____

Current Pharmacy: _____ Phone: _____

ARE YOU ON ANY MEDICATIONS? YES OR NO (CIRCLE ONE) IF SO. PLEASE LIST:

Name of Medication	Strength (mgs)	Dosage (Time/Day)

Are you allergic to any medications? Yes Or No (Circle One) If yes, please list:

I have reported my medication/allergy list to the best of my knowledge and do not hold West Georgia Urology Associates, PC accountable for any inaccuracies.

_____ _____

Patient Signature Date:

West Georgia Urology

West Georgia Urology Associates, PC

PATIENT REGISTRATION FORM

_____ _____ _____

First Name MI Last Name

Social Security # _____ Cell (primary) Phone Number: _____

_____

Address City State Zip Code

Date of Birth: _____ Age: _____ Marital Status: _____

Permission to contact you via Text, Voice, and Email: Yes or No

Primary Care Physician: _____

Employment Contact Information

Employed: Yes or No Employer: _____ Phone: _____

Emergency Contact Information

Name: _____ Relationship: _____ Phone: _____

Medical Insurance Information

Primary Insurance Company: _____ Subscriber's Name: _____

Subscriber's ID: _____ Subscriber's DOB: _____

Secondary Insurance Company: _____ Subscriber's Name: _____

Subscriber's ID: _____ Subscriber's DOB: _____

Subscriber's Employer: _____

West Georgia Urology Associates, PC
Acknowledgement of Notice of Privacy Policy

Patient Name: _____ Date of Birth: _____

I understand that **WEST GEORGIA UROLOGY** as my healthcare provider, is permitted to share my health information for treatment, payment and healthcare operations. I have been given a chance to review a current copy of WEST GEORGIA UROLOGY's Notice of Privacy Practices describing how my health information will be used and shared by WEST GEORGIA UROLOGY. I understand that WEST GEORGIA UROLOGY has the right to change its Privacy Practices and that I may obtain a current copy by contacting the WEST GEORGIA UROLOGY Privacy Officer at 770-834-6988. My signature below constitutes my acknowledgement that I have been given a chance to review a current copy of WEST GEORGIA UROLOGY's Notice of Privacy Practices.

If a patient is physically unable to provide his/her signature OR signs with a mark, print his/her name on the appropriate line below and record the signature of two (2) responsible persons who witness that such person understands the nature of the WEST GEORGIA UROLOGY Notice of Privacy Practices and the purpose of this acknowledgement. If patient is not capable of acknowledging the notice because of medical condition, complete the following:

_____ _____
Patient/Legal Guardian/Relative Signature Date

_____
Legal Guardian/ Relative Relationship to Patient

_____ _____ _____ _____
Witness #1 Date Witness #2 Date

I understand the restrictions placed on WEST GEORGIA UROLOGY by federal and state law regarding inability to share or discuss my medical information with others without my express written consent to do so. Therefore, **I request that WEST GEORGIA UROLOGY discuss (initial one of the following):**

_____ **all aspects of my medical condition, care and treatment** OR
_____ **only the following aspects of my medical condition, care and treatment:** _____

_____
(PLEASE PRINT CLEARLY)

_____ _____
Person's Name Relationship to Patient

_____ _____
Person's Name Relationship to Patient

_____ Date: _____
Patient's Signature

CONSENT TO RELEASE OF

PATIENT INFORMAITON

West Georgia Urology Associates, PC (WGUA) is a medical practice that focuses on surgical and medical diseases of the male and female urinary-tract system and the male reproductive organs. WGUA's physicians are also affiliated with WGUASC, LLC (WGUASC). WGUASC is an ambulatory surgery center at which physicians perform procedures/surgeries.

As a patient of WGUA, you will provide WGUA with a variety of health and other personal information to enable your physician to diagnose and treat your medical conditions. Also, in the course of providing treatment, WGUA will collect additional information related to your health. For purposes of this Consent Form, the information that you provide WGUA and the information that WGUA collects in the course of providing treatment is referred to as the "Personal Health Information".

Should your physician determine that you require a procedure that will be performed at WGUASC, and should you consent to the performance of that procedure, then WGUASC will need the Personal Health Information that is in possession of WGUA.

BY SIGNING BELOW, YOU ARE AUTHORIZING WGUA TO SHARE YOUR PERSONAL HEALTH INFORMATION WITH WGUASC IN THE EVENT THAT YOU ARE SCHEDULED IN THE FUTURE TO UNDERGO A PROCEDURE AT WGUASC. THIS WILL ELIMINATE THE NEED FOR YOU TO PROVIDE WUGASC WITH THE SAME PERSONAL HEALTH INFORMATION THAT YOU HAVE ALREADY PROVIDED TO WGUA.

I HEREBY AUTHORIZE WGUA TO RELASE MY PERSONAL HEALTH INFORMATION TO WGUASC IN THE EVENT THAT I AM SCHEDULED AT A FUTURE DATE TO UNDERGO A PROCEDURE AT WGUASC. IF AT A FUTURE DATE I AM SCHEDULED TO UNDERGO A PROCEDURE AT WGUASC, WGUA SHALL NOT BE REQUIRED TO OBTAIN ANY FURTHER CONSENT FROM ME BEFORE SHARING MY PERSONAL HEALTH INFORMATIN WITH WGUASC.

Signature of Patient or Personal Representative

_____ _____

Signature Date:

_____

Print Name