COMPREHENSIVE UROLOGIC CARE

Lake Barrington: 22285 N Pepper Rd #201, Lake Barrington, IL 60010

Elgin: 1600 N Randall Road #201, Elgin, IL 60123

Hoffman Estates: 1585 N Barrington Road #206, Hoffman Estates, IL 60169

Phone: 847-382-5080

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info@compurocare.com

www.compurocare.com

Please enter patient information

First Name: | Middle Name: | Last Name: | Date of Birth:

Gender:
☐ Female ☐ Male

Social Security Number: (Required for Online Chart Access)

Marital Status:
☐ Single ☐ Married ☐ Domestic Partner
☐ Separated ☐ Divorced ☐ Widowed

Street Address: | Apt./Unit #:

City: | State: | Zip Code:

Mobile Phone: | Home Phone: | Work Phone:

Email Address: (Please avoid using shared or work email)

Employer: | Employer Address:

Emergency Contact Name: | Emergency Contact Relationship: | Emergency Contact Number:

Primary Insurance Company: | Member ID:

Please indicate:
☐ PPO ☐ HMO ☐ Medicare
☐ Self Insured

Insured Name: | Insured Date of Birth:

Client Relationship to Insured:
☐ Self ☐ Spouse
☐ Child ☐ Other

Secondary Insurance Company: | Member ID:

Please indicate:
☐ PPO ☐ HMO ☐ Medicare
☐ Self Insured

Insured Name: | Insured Date of Birth:

Client Relationship to Insured:
☐ Self ☐ Spouse
☐ Child ☐ Other

Physician Care Team

Primary Care Physician: | Referring Physician:

Past Urologist/s.

Have you seen a Urologist before?
☐ Yes ☐ No
☐ Information unavailable

Name of Previous Urologist | Last seen?

Patient Name: _____ Date of Birth: _____

Please enter Pharmacy Name and Address

Primary Pharmacy Name _____ Primary Pharmacy Address _____

Secondary Pharmacy Name _____ Secondary Pharmacy Address _____

Mail Order Pharmacy Name _____ Mail Order Pharmacy Address _____

Past Medical History: check any illnesses and tell us when they occurred.

- ☐ None _____
- ☐ Anemia _____
- ☐ Arthritis _____
- ☐ Asthma _____
- ☐ Atrial Fibrilation _____
- ☐ Breast Cancer _____
- ☐ Coronary Artery Disease _____
- ☐ COPD _____
- ☐ Chest Pains (Angina) _____
- ☐ Crohns _____
- ☐ Depression _____
- ☐ Diabetes _____
- ☐ Diverticulosis _____
- ☐ Gout _____
- ☐ GERD _____
- ☐ Heart Attack (Myocardial Infarction) _____
- ☐ Hepatitis _____
- ☐ Hypertension (High Blood Pressure) _____
- ☐ Hypothyroidism _____
- ☐ Irritable Bowel Syndrome _____
- ☐ Migraines _____
- ☐ Hypercholesterolemia (High Cholesterol) _____
- ☐ Osteoporosis _____
- ☐ Paraplegia _____
- ☐ Quadriplegia _____
- ☐ Seizures _____
- ☐ Spine Problems/Back Pain _____
- ☐ Stroke/CVA _____
- ☐ Other _____

Past Surgical History: check past surgeries and tell us what year they occurred.

- ☐ None _____
- ☐ Amputation _____
- ☐ Angioplasty _____
- ☐ Appendectomy _____
- ☐ AP Resection _____
- ☐ AV Fistula _____
- ☐ Back Surgery _____
- ☐ Cardiac Bypass _____
- ☐ Colon Resection _____
- ☐ Cystectomy _____
- ☐ Gall Bladder Removal _____
- ☐ Gastric Bypass _____
- ☐ Hernia Repair _____
- ☐ Hysterectomy _____
- ☐ Indigo Laser _____
- ☐ Kidney/Ureter Stone (Basketing) _____
- ☐ Kidney/Ureter Stone (ESWL) _____
- ☐ Mesh Hernia Repair _____
- ☐ Orchiectomy _____
- ☐ Other _____
- ☐ Orthopedic Surgery _____
- ☐ Peripheral Bypass Surgery _____
- ☐ Prostate Surgery (Microwave TARGIS) _____
- ☐ Prostate Surgery (TUNA) _____
- ☐ Prostate Surgery (TURP) _____
- ☐ Radiation Therapy (Prostate Cancer) _____
- ☐ Radical Prostatectomy _____
- ☐ Small Bowel Resection _____
- ☐ Tonsillectomy _____

Past Urologic History: check any illnesses and tell us when they occurred.

☐ None _____
☐ Impotence (male) _____
☐ Kidney Stones _____
☐ Renal Insufficiency / Failure _____
☐ Vasectomy (male) _____
☐ Bladder Cancer _____
☐ Kidney Cancer _____
☐ Prostate Cancer (male) _____
☐ Urinary Incontinence _____
☐ Other _____
☐ Enlarged Prostate (BPH) (male) _____
☐ Kidney Cyst _____
☐ Prostatitis (male) _____
☐ Urinary Tract Infections (UTI) _____

Family History: check box(es) for any illnesses in your immediate family.

Condition	None	Father	Mother	Brother	Sister	Family
None						
Asthma						
Bleeding Disorder						
Breast Cancer						
Diabetes						
Enlarged Prostate						
Heart Disease						
High Blood Pressure						
Kidney Stones						
Lung Cancer						
Mental Illness						
Prostate Cancer						
Other						

Social history

Do you smoke?
☐ Yes ☐ No

How many packs per day?
☐ Third ☐ Half ☐ One ☐ Two ☐ Two +

Past smoking?
☐ Yes ☐ No

Do you drink alcohol?
☐ Yes ☐ No

How much?
☐ Daily ☐ Dependent ☐ Habitual ☐ Heavy ☐ Occasionally ☐ Socially

Past drinking
☐ Yes ☐ No

Allergies: check box(es) for any known allergies, define reaction and severity of reaction.

	None Known	Known Allergies?	Define Allergic Reaction	Severity (Mild, Moderate or Severe)
None Known				
Ace Inhibitors				
Aspirin				
Cephalosporins (eg. Keflex, Duricef, Ceftin, Ceclor)				
Cipro				
Codeine				
Demerol				
Erythromycin				
Ibuprofen				
Iodine/Contrast				
Latex				
Levaquin				
Macrobid				
Morphine				
Peanuts				
Penicillin (eg. Pen VK, Amoxicillin, Augmentin)				
Shell Fish				
Sulfonamides				
Tetracycline				
Other				

If other allergies were not previously listed, please specify:

	Allergic to?	Define Allergic Reaction	Severity (Mild, Moderate or Severe)
1			
2			
3			
4			
5			

Please list all medications/supplements, dosage, frequency and reason for taking.

	NONE	Medicine	Dosage	Frequency	Reason for taking
NONE					
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					

Do you currently have any problems related to the following? Check applicable box if Yes.

Constitutional
☐ Fever ☐ Chills ☐ Fatigue ☐ Weight Loss ☐ Dental History

Neurological
☐ Tremors ☐ Dizzy Spells ☐ Memory problems ☐ Seizures

Endocrine
☐ Excessive Thirst ☐ Hot/Cold Intolerance ☐ Hot Flashes

Ear/Nose/Throat/Mouth
☐ Ear Infection ☐ Sore Throat ☐ Sinus Problems

Genitourinary
☐ Incontinence ☐ Painful Urination ☐ Frequent Urination

Hematologic/Lymphatic
☐ Enlarged Lymph Nodes ☐ Abnormal Bruising ☐ Anemia

Respiratory
☐ Wheezing ☐ Frequent Cough ☐ Shortness of Breath

Musculoskeletal
☐ Joint Pain ☐ Neck/Back Pain ☐ Bone Pain

Gastrointestinal
☐ Abdominal Pain ☐ Nausea/Vomiting ☐ Indigestion/Heartburn
☐ Loss of Appetite

Eyes
☐ Blurred Vision ☐ Double Vision ☐ Glaucoma

Psychiatric
☐ Anxiety ☐ Depression ☐ Irritable

Integumentary
☐ Skin Rash ☐ Boils ☐ Persistent Itch

Cardiovascular
☐ Chest Pain ☐ Varicose Veins ☐ High Blood Pressure

Reproductive (Male)
☐ Erection Problems ☐ Ejaculation Problems ☐ Infertility

Reproductive (Female)
☐ Menopause ☐ Vaginal Deliveries ☐ Irregular periods

Immunization (within last 1 Yr.)
☐ Influenza, split virus ☐ Influenza, vaccine ☐ Influenza,Intranasal
☐ Pneumococcal vacc.

Notes / Other

Height (ex: 5ft., 6in.)

Weight (ex: 150 lbs.)

Notice of Privacy Practice and HIPAA Consent

Patient Name: _____ Date of Birth: _____

I acknowledge that I have been made aware of CUC's Notice of Privacy Practices, which is posted on their website, as well as available upon request in their office.

☐ I Place No Restrictions ☐ Restrict all of my Protected Health Information, except for the following individuals

Name _____ Name _____

Relationship _____ Relationship _____

Date of Birth _____ Date of Birth _____

NOTICE OF INSURANCE RELEASE OF INFORMATION AND AUTHORIZATION FOR PAYMENT

I authorize the release of any medical or other information acquired in the course of my examination or treatment to insurance carriers.

I authorize payment of medical benefits direct to Comprehensive Urologic Care for medical/surgical services rendered to me or my dependents.

I understand that it is my responsibility to satisfy any payment obligations required by my insurance carrier at the time of service and am financially responsible for any services not covered by my insurance.

TEXT MESSAGING POLICY

I authorize Comprehensive Urologic Care to text me regarding appointment reminders details and authorization.

I understand that it is my responsibility to notify the practice if any change of information to avoid disruption of communication.

ACKNOWLEDGEMENT OF OFFICE POLICIES

I acknowledge that I have been made aware of CUC's Office Policies, which is posted on their website, as well as available upon request in their office.

Power of Attorney:

Do you have a POA?
☐ Yes ☐ No

If you answered "Yes" please provide a copy of your signed POA forms.

(If you do not provide us with the correct documentation we cannot discuss your care with your designated POA)

POA Name: _____ POA Phone Number: _____

Signature for Consent

Patient Signature: _____ Today's Date: _____

Financial Policy Consent

Patient Name: _____ Date of Birth: _____

CO-PAYS

The patient is expected to present an insurance card at each visit. All co-payments and past due balances are due at time of check-in unless previous arrangements have been made with a billing specialist. We accept cash, check or credit cards. Absolutely no post-dated checks will be accepted. Failure to comply with our copay policy will result in a cancelled appointment.

INSURANCE CLAIMS

Insurance is a contract between you and your insurance company. In most cases, we are NOT a party of this contract. We will bill your primary and secondary insurance company as a courtesy to you. In order to properly bill your insurance, we require that you disclose all insurance information including your primary and secondary insurance coverage, as well as any change of insurance information. Failure to provide complete insurance information may result in patient responsibility for the entire bill. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. If your insurance company is not contracted with us, you agree to pay any portion of the charges not covered by insurance, including but not limited to those charges above the usual and customary allowance. If we are out of network for your insurance company and your insurance pays you directly, you are responsible for payment and agree to forward the payment to us immediately.

PARTICIPATING INSURANCES

If your insurance plan is one with which we are not a participating provider, you will be responsible for payment in full. However, as a courtesy, we will file your initial insurance claim and if not paid within 30 days you will be responsible.

REFERRALS AND PREAUTHORIZATION

Certain health insurances (HMOs, POs, etc.) require that you obtain a referral or prior authorization from your Primary Care Physician (PCP) before visiting a specialist. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain a referral and/or preauthorization may result in a lower or no payment from the insurance company, and the balance will be your responsibility. Alternative payment arrangements or rescheduling of your appointment may be necessary if not obtained.

SURGERY PREPAYMENTS

Comprehensive Urologic Care, SC collects your payment for a surgery at the time when the surgery is scheduled. Your prepayment is based on an estimate of your expected financial responsibility. This is an estimate only. You are responsible for any unpaid balance after your insurance has been billed. We reserve the right to reschedule your surgery until prepayment has been made.

CANCELLATION POLICY

The patient will receive an automated notification (email, text, or phone call) 72 hours prior to the scheduled visit as a reminder. Please note, as time has been reserved for you, we require a 24-hour notice for all canceled appointments. When patients do not show up as scheduled it is disruptive to the provider, staff and other patients. We respect your time and appreciate your understanding in this manner. For a patient who who cancel with less than 24 hours notification or does not show for their scheduled appointment a non-refundable charge will be assessed to the patients account based on the type of appointment: X-ray ($75.00), Established Patient Visit ($100.00), Procedure/Imaging: CT and Ultrasound/urodynamic ($250.00) and New Patient Visit ($300.00). This fee is non-billable to insurance plans.

ACKNOWLEDGEMENT OF FINANCIAL POLICY

I acknowledge that I have been made aware of CUC's Office Policies, which is posted on their website, as well as available upon request in their office. I also acknowledge that I have reviewed all of the information above and I confirm its accuracy signing below.

Signature for Consent

Patient Signature: _____ Today's Date: _____

Self-Pay Policy Consent

Patient Name: _____ Date of Birth: _____

SELF-PAYING ACCOUNTS

Self-paying accounts are patients without insurance coverage, patients covered by insurance plans in which our practice does not participate, or patients without an insurance card on file with us. Liability and workers' comp cases will also be considered self-pay accounts. We do not accept attorney letters or contingency payments. It is always the patients' responsibility to know if our office is participating with their plan. If there is a discrepancy with our information, the patient will be considered self-paying unless otherwise proven.

Self-paying patients will be required to pay $366.00 at the initial appointment. In the event your provider carries out additional procedures/tests, you will be required to pay for those at the time of check out.

FOLLOW UP APPOINTMENTS

Our office does offer self-pay patients a discount of 25% if paid the day of. If unable to pay the same day we do require a payment and will have you speak to a billing specialist to set up a payment plan. It is never our intention to cause hardship to our patients, only to provide them with the best care possible and the least amount of stress.

ACKNOWLEDGEMENT OF SELF-PAY POLICY

I acknowledge that I have been made aware of CUC's Office Policies, which is posted on their website, as well as available upon request in their office. I also acknowledge that I have reviewed all of the information above and I confirm its accuracy signing below.

Signature for Consent

Patient Signature: _____ Today's Date: _____

Patient Waiver/Consent to Pay

Patient Name: _____ Date of Birth: _____

Patient Waiver/Consent and Agreement to Pay

I, _____, understand that by signing this waiver, I have read Comprehensive Urologic Care, SC's Financial Policy and I am agreeing to pay for any non-covered services provided by Comprehensive Urologic Care, SC.

Every billing effort will be made to obtain reimbursement of the services provided from my insurance carrier. In the event of a denial of payment by the insurance carrier, I agree to be responsible for the allowed amount of charges or a remaining balance after my insurance has paid in full. Also, if I fail to provide the correct/unpaid insurance information at the time of services, for our staff to obtain preapproval, I agree to be responsible for the allowed amount of the charges.

I have read and understand the Waiver/Consent to Pay Form and accept all items listed above.

Signature for Consent

Patient Signature: _____ Today's Date: _____

Patient Name: _____ Date of Birth: _____

Zero Tolerance Policy

While patients are the key to our practice, patient abuse verbal or otherwise will not be tolerated by Comprehensive Urologic Care, SC. While we strive to put patient care first, that will not come at the expense of abuse to our staff. Comprehensive Urologic Care, SC observes a "Zero Tolerance" approach to staff abuse (by phone or in person). Of course, resolution is always preferred outcome; however, dismissal from the practice can/will be sought in hostile scenarios.

As a returning/incoming patient of Comprehensive Urologic, SC. I have read and understand the above policy.

Signature for Consent

Patient Signature: _____ Today's Date: _____