UROLOGIC INSTITUTE OF NEW JERSEY, P.A.

REGISTRATION
(Please Print)

DATE: ___________ Home Phone: ____________________

Cell Phone: ____________________

E Mail ____________________________ Work Phone: ____________________

PREFERRED COMMUNICATION: ☐Phone ☐Mail

PATIENT NAME:

(Last) ____________________ (First) ______________ (Middle Initial) ______

Street Address: ________________________________ Apartment __________

City: ____________________ State ________________ Zip Code __________

Sex M ____ F ____ Age ______ Date of Birth __________ Martial Status ________

SS # ____________________ Race: ____________ Ethnicity: __________

PRIMARY LANGUAGE: ______________ PHARMACY PHONE ________________

INSURANCE STATUS:

Patient Employed By: ____________________ Occupation: ______________

Business Address: ____

Name of Primary Insurance: ____________________ ID#: ______________

Group#: ________ Subscriber: ____________ Birthdate: ________ Relationship _____

Name of Secondary Insurance: ____________________ ID#: ______________

Group#: ________ Subscriber: ____________ Birthdate: ________ Relationship _____

EMERGENCY NOTIFICATION:

In case of emergency, who should be notified? ________________ Phone: __________

I hereby give permission to disclose personal health information to: ________________

Relationship: ____________________ Telephone #: ____________________

PRIMARY PHYSICIAN CONTACT:

Primary Care Physicians Name: ________________________________

Address ________________________ City: ____________ State: _____

Telephone #: ________________ Fax #: ________________

Urologic Institute of New Jersey

Sergey Rome, MD   Steve Lebovitch, MD

Consultation

Patient Name: ______________________ ***DOB*** ______________ ***Date*** __________

Telephone: ______________________ ***Referred By*** ______________________

HPI(Location, Duration, Timing, Quality, Severity, Modifying Factors, Associated Symptoms)

1) ______________________________

____

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2) ______________________________

____

3) ______________________________

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Review of systems: Circle present symptoms

Const: Fever Chills Fatigue Weight Change
Eyes: Vision Change Dry Eyes
Heart: Chest Pain Palpitations swelling in legs
Resp: Cough Wheeze Short of Breath
GI: Abd pain Nausea Vomiting Diarrhea
Constipation, Blood in stool tarry stool
MS: Pain Stiffness Joint/Back
H-L: Bleeding Clotting Problems
Endo: Thirst Heat/Cold intolerance/ Night Sweats
Skin: Rash Lesions Ulcers
Neuro: Headaches Dizziness

Urologic ROS (Please circle present symptoms)

Decreased urine Flow Post-voiding dribbling
Sense of incomplete emptying
Frequent voiding Urge to urinate often
Getting up at nights to urinate
Leaking urine during cough, sneeze
Leaking urine without warning
Blood in Urine (seen/told by doctor)
Stones in Kidney/Bladder
Infection in Bladder/Kidney
Problems with getting/maintain erections
Problems with sexual desire
Loss of morning Erections

Family History

Kidney/Bladder/Prostate Cancer
Kidney Stones
Enlarged Prostate
Diabetes/High Blood Pressure/Heart Disease

Past Surgical History

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Past Medical History

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Social History

Smoker Y/N   Ex-Smoker Y/N
Alcohol Y/N   Daily/Socially
Occupation: Working/Retired

Allergies Y/N

____

____

____

Past Urologic History

____

____

____

Medications N/Y

____

____

____

____

NEW JERSEY
UROLOGY
Excellence In Care

1515 Broad Street, Suite B130, Bloomfield, NJ 07003-3085
P 973 873 7000 • F 973 743 8943

CANCELLATION AND NO SHOW POLICY

At Urologic Institute of N.J., we understand that situations arise in which you must cancel your appointment. Should you have to cancel, it is requested that you do so at least 24 hours in advance of your scheduled visit. In doing so, it will enable us to schedule someone who may be waiting for an appointment in your timeslot.

Office appointments cancelled with less than 24 hours' notice and not rescheduled will be subject to a **$50.00** cancellation fee.

Procedure cancellations without 24 hour notification will be subject to a **$150.00** cancellation fee. Patients who fail to show for an appointment or procedure without a call to cancel will be considered **"No Show"**, and will be subject to a **$150.00 No Show** fee.

The cancellation and No Show fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment.

We understand that Special unavoidable circumstances may cause you to cancel within 24 hours. Fees in this instance may be waived with approval.

Our practice firmly believes that a quality physician/patient relationship is based upon understanding and good communication.

Please sign that you have read, understand and agree to this Cancellation and no show policy.

______________________________ **Date of Birth**________________________

Patient Name (Please Print)____________________________________

STATEMENT OF PATIENTS' FINANCIAL RESPONSIBILITIES

Our goal is to provide our patients with excellent and affordable medical care. To accomplish this goal, the practice has designated a financial officer who is able to help you understand the nature of any bills that you may receive, resolve issues with your insurance company, and establish sensible payment plans.

Please review the following billing procedures that are followed by our practice.

- Pursuant to federal and state law, as well as our contract with insurance carriers, our practice is required to collect all patient responsibility payments [patient responsibility payments include co-payments, coinsurances, and deductibles]. To ensure efficiency in our billing, it is the policy of our practice to **collect patient responsibility amounts at the time of your visit.**
- It is your responsibility to understand your insurance plan. While we work very hard to help ensure that your insurance covers services provided, there is a large number of different insurance plans, and we are unable to know all of them. If your insurance requires a referral, it is *your* responsibility to request your primary care doctor to issue one. If you arrive for your appointment without a referral, you will not be able to see your doctor.
- If your physician participates with your insurance plan, after your appointment, our billing department will submit a bill to your insurance company (insurance claim). The insurance claim will list all the services that have been provided to you as well as diagnosis codes for each complaint that you have related to your doctor. Upon receiving our claim, your insurance company may send you an explanation of benefits ("EOB"); **it is NOT a bill** – it is simply a statement from your insurance company explaining what is being paid for and what might not be covered. Please save the EOB for your records. If you receive a bill from our office that is inconsistent with the EOB you received from your insurance company, please contact our office immediately.
- If more than 60 days have passed from the time of your appointment, and your insurance company has not paid your doctor, you should contact your insurance company.
- If your insurance company denies your claim, the **charged amount of the claim becomes your responsibility.** Your insurance company may deny the claim for reasons that may be stated in your insurance policy (e.g. some diagnoses may be considered non-covered services under your contract, or your insurance company may establish that your condition is pre-existing). If you believe that the claim was erroneously (or incorrectly) denied, **contact our billing supervisor immediately. Our billing supervisor will work with you to attempt to get payment from your insurance company.** Depending on the reason for the denial, the balance due may be reduced to our cash payment rate.
- If you receive a bill from our practice, please forward the payment to our office at your earliest convenience and prior to the due date. If you are unable to afford the payment, please contact our billing supervisor who will set up a payment plan for you. If you believe that you have received the bill in error, please contact our office. Please be aware that if no payment is received within 90 days of the due date on the bill, the practice will engage in collection efforts, which may include forwarding your account to a credit-reporting collection agency.
- If your physician does not participate with your insurance company, your cash-rate payment is due at the time of your visit. If you have out-of-network benefits with your insurance company, our office will help you submit a claim for reimbursement.

/e work very hard to make sure that our services are affordable and that your insurance company pays what it supposed to. Please reach out to our billing supervisor if you have a question or an issue.

ate____________________ Patient Name____________________________________

ignature____

NJ Urology
ACKNOWLEDGEMENT OF RECEIPT OF SUMMARY NOTICE OF PRIVACY PRACTICES

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The notice contains participant rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office at (973) 873-7002.

You have the right to request that we restrict how protected information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke the Consent in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. NJ Urology provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

The participant understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations. NJ Urology has a Notice of Privacy Practices and that the participant has the opportunity to review this notice.
- NJ Urology reserves the right to change the Notice of Privacy Practices.
- The participant has the right to request restrictions to the uses of their information but NJ Urology does not have to agree to those restrictions.
- The participant may revoke this Consent in writing at any time and full disclosures will then cease.
- NJ Urology may condition receipt of treatment upon the execution of this consent.

I have received a copy of the Summary Notice of Privacy Practices. I understand that I may also request a copy of the practice's complete Notice of Privacy Practices if I so desire.

____
Name of Participant (print)

________________________________ ____________
Signature of Participant Date

________________________________ ____________
Signature of Participant Representative Date
(Required if participant is a minor or an adult who is unable to sign this form)

____
Relationship of Participant Representative to Participant Print Name

PATIENT NOTICE REGARDING PATHOLOGY CHARGES

Please note that charges for laboratory testing services (e.g. specimen, tissue, blood or bodily fluids) are not included in your physician's fees and are separate from any payments made to your doctor during your office visit. NJ Urology (NJU) will submit a claim to your insurance carrier for any laboratory test performed at the request of your physician; you will receive a statement for any amount you are required to pay after insurance has paid its portion of the bill or denied payment. By ensuring our office has your most current insurance information, you can help expedite this process.

You may receive a bill from a laboratory which may appear to be a duplicate for a service performed. However, these charges are not included in any other statement. The doctor's charge relates to the professional services provided during your office visit or surgical procedure and the pathology bill relates to the professional services associated with the interpretation or diagnosis of the specimen, tissue, blood or bodily fluids.

If you have questions regarding your pathology statement or outstanding balance, or would like to make a payment, please contact Patient Account Services at 877-366-5876.

PATIENT/RESPONSIBLE PARTY ACKNOWLEDGEMENT AND AGREEMENT:

I acknowledge that I have read and fully understand the **NOTICE REGARDING PATHOLOGY CHARGES.** I understand that I am financially responsible for non-covered services not paid by the insurance carrier within the confines of my policy.

______________________________ ____________

Signature, Patient Date

______________________________ ____________

Signature, Financially Responsible Party (if not patient) Date

Rev. 01/01/15