

Thank you for entrusting KCUC with your urologic care. Our physicians and office staff are eager to serve you.

In order to provide you with the best services possible, we ask that you please complete the enclosed paperwork and bring it with you to your appointment.

- **Please arrive 15 minutes early for your appointment. If your paperwork has not been completed, please arrive 30 minutes before your appointment or we reserve the right to reschedule your visit.**
- **If you have had any x-rays, CT scans, MRI's, bone scan or any records that pertain to your urology needs, please bring your films with you at the time of your appointment.**
- Please bring your insurance cards and medication list with you.
- Please be prepared to pay your co-pay at the time of your visit
- If your insurance requires a written referral to see a urologist (specialist), please bring a referral form completed by your primary care physician at the time of your visit. If you arrive without a valid referral form, we reserve the right to reschedule your appointment because of your insurance requirements.
- **Self-pay patients please come prepared to make payment in full at the time of your visit. If you pay in full at the time of service your charge will be discounted 30%. If you cannot pay in full please be prepared to render a minimum of \$100.00, we will bill you for the additional charges.**
- **Please be advised that a NO SHOW fee of \$50 will apply if you fail to cancel or reschedule your appointment 24 hours prior.**

Thank you for your assistance in helping us expedite your appointment!



Patient Financial Policy

Thank you for choosing KCUC as your urology health care provider. We are committed to providing you with the highest quality medical care, in a supportive, empathetic and respectful manner. If you have special needs, we are here to work with you.

The following information is provided to avoid any misunderstanding or disagreement concerning payment for professional services. Your clear understanding of our "Patient Financial Policy" is important to our professional relationship. Please ask if you have any questions about our fees, our policies or your responsibilities. Carefully review the following information and return this form to us with your signature and today's date.

Insurance

It is the patient's responsibility to provide the clinic with current insurance information since our practice participates with a variety of insurance plans. **Your insurance policy is a contract between you and your insurance company.** We consider an insurance card similar to a credit card because you are asking us to bill another party (your insurance) for charges for the services you have been provided.

As a courtesy, we will file your claims for you. However, we will not become involved in disputes between you and your insurance carrier. This includes, but is not limited to, deductibles, co-payments, non-covered charges and "usual and customary" charges. We will supply information as necessary. **You are ultimately responsible for the timely payment of your account.**

If we DO participate with your insurance company, all services performed in our office will be submitted to them, unless we have received prior notification of non-covered services. All copays and deductibles are the patient's responsibility. Copay's are due at the time of service.

If we DO NOT participate with your insurance company, we will file the insurance claim and accept the payment, but we will not accept the contractual adjustment. That balance will be the patient's responsibility and any balances that are not covered will be the patient's responsibility.

Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. It is your responsibility to know if a certain procedure is not covered, please check your insurance handbook.

It is your responsibility to bring any required referrals for treatment at, or prior to the visit. If you do not have the referral, your visit may be rescheduled, or you may be financially responsible.

Co-pays

Your insurance company requires us to collect co-payments at the time of service. Waiver of co-payments may constitute fraud under state and federal law. Please help us in upholding the law by paying your co-payment at each visit. For your convenience we accept cash, check, or credit card (MasterCard, VISA, AMEX or DISC). If you do not bring proper payment to your visit, you may be asked to reschedule your appointment except in the case of a medical emergency.

Patients with NO Medical Insurance

If you do not have group or individual medical insurance, payment for professional services is expected at the time of service. As a courtesy, the practice offers a 30% discount of billed charges, to anyone with no insurance if paid at the time of service. This discount is available **ONLY ON** the actual date of service.

If unable to pay at the time of service, at the discounted rate (30% of billed charges), we require a \$100 down-payment toward all billed services, which will be at the full fee amount. If you have questions, we would recommend that you contact our billing department (913-341-7985) prior to your appointment.

Waiver of Patient Responsibility

It is the policy of the practice to treat all patients in an equitable fashion related to account balances. The practice will not waive, fail to make reasonable collection efforts, or discount co-payments, co-insurance, deductibles, or other patient financial responsibility in accordance with state and federal law, as well as participating agreements with payers. Full or partial financial responsibility may only be waived in accordance with the KCUC's Charity Care Policy.

Un-Paid Balances & Payment Arrangements

If your insurance company has not paid the balance in full or you are unable to pay the balance in full, you will receive a statement notifying you of the amount due, you may call our billing office at (913)-341-7985 to set up payment arrangements if necessary. If you fail to make payment in full, within 120 days, for the services that are rendered to you, your outstanding balance may be considered for further collection activity.

Late Arrivals

A late arrival, not considered to be the responsibility of KCUC, will be registered and worked into the schedule as soon as possible. If the patient is more than 30 minutes late, the appointment may be rescheduled.

No-Shows

KCUC may charge a \$50 “no-show” fee in the event that you do not show for your appointment and in which you do not cancel or reschedule with 24 hours’ notice. This will be applied to your account.

Returned Checks

The charge for a returned check is \$30 payable by cash or money order. This will be applied to your account in addition to the insufficient funds amount. You may be placed on a “Cash Only” basis following any returned check.

Minors

Our practice does not treat minors without the presence of a parent(s) or guardian(s). If the patient is a minor (under 18 years of age), the parent(s) or guardian(s) is responsible for full payment and will receive the billing statements.

Divorce Decrees

KCUC is not party to any divorce decrees, so any outstanding balance is still the responsibility of the patient or the legal guarantor of the patient, in the case of a minor.

Special Form Fees

If you require any special forms to be completed (for example; FMLA, Work Comp or Disability) by a physician, the patient/guarantor will be responsible for any fees related to the service.

Medical Record Copies

Your medical record is the property of KCUC. If you would like to request a copy of your medical records, for yourself or to be mailed to another provider, please contact your physician’s office to obtain the proper Medical Records Request form.

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) KCUC may charge a reasonable cost-based fee pursuant to 45 CFR 164.524. KCUC has developed a fee structure that is slightly below the Missouri and Kansas Department of Health Services maximum standards:

- Clerical fees \$18.50
- For the first 250 pages \$ 0.50 per page (maximum \$125.00)
- For each page after 250 \$ 0.45 per page
- Plus actual postage

KCUC must emphasize that as healthcare providers, our relationship is with you, not your insurance company. While filing the insurance claims is a courtesy we extend to our patients, all charges are strictly your responsibility from the time services are rendered. Therefore, it is often necessary for you to inquire and explore your benefits with your insurance carrier. We do realize that temporary financial problems may affect timely payment, but if such problems do arise, we encourage you to contact us promptly for assistance in the management of your account at 913-341-7985.

KCUC believes that a good patient-to-physician relationship is based upon understanding and good communication. Thank you for understanding our “Patient Financial Policy”. We appreciate the opportunity to provide you with your urological care. Your assistance and cooperation will be most appreciated.



If you're a new patient, please circle one of the following to help us know how you heard about KC Urology:

PCP Radio Internet TV Other _____

Date: _____

PATIENT INFORMATION

Patient Name: _____ DOB: _____ Age: _____

Address: _____ City/State: _____ Zip: _____

Male or Female (circle one) Last 4 digits Social Security #: _____ Marital Status S__M__D__W__ No. of Children: _____

Home Phone: _____ Cell Phone: _____ e-mail: _____

Referring Physician: _____ Phone: _____

Primary Care Physician: _____ Phone: _____

Primary Pharmacy: _____ Address: _____

City/State/Zip: _____ Phone #: _____

Mail Order Pharmacy: _____ Address: _____

City/State/Zip: _____ Phone #: _____

Insurance

Will VA benefits be used for this visit? _____ If yes, please provide the referral #: _____

Is the patient employed? _____ If yes, are you covered by a Group Health Plan? _____

Is this patient covered under a COBRA policy? _____

Is this service related to a Work Comp accident or an Auto accident? _____ If yes, you will be provided additional forms

Primary Insurance: _____ ID# _____ Group # _____

Insured's Name: _____ Date of Birth: _____

Relationship to Patient: _____ Contact Phone #: _____

Secondary Insurance: : _____ ID# _____ Group # _____

Insured's Name: _____ Date of Birth: _____

Relationship to Patient: _____ Contact Phone #: _____

Emergency PATIENT SPOUSAL / PARENT CONTACT INFORMATION

Name: _____ Relationship to Patient _____

Home Phone: _____ Cell Phone: _____

(Patient Name)

INSURANCE CONSENT

I hereby authorize release of information to my insurance companies and payments to be made directly to my physicians. This form may be used for all of my insurance companies, and I authorize this practice to act as my agent to help me secure payment from my insurance companies. I understand that I am responsible for my bill and am subject to attorney fees, collection fees/charges, and any other charges incurred if my portion of the balance is not paid when due.

Initials

MEDICAL RECORDS RELEASE AUTHORIZATION

I authorize the Kansas City Urology Care, PA to release to the appropriate person, corporation, or other entity any diagnostic and therapeutic information (including any treatment for alcohol or drug abuse and any psychiatric or psychological treatment) as may be necessary to determine health care benefits entitlement for me under any insurance policy or other type of health care benefits plans or as may be appropriate for the purpose of analysis or research regarding reimbursement of doctors and other health care providers. I authorize Kansas City Urology Care, PA to process payment claims for health care services provided to me. I agree to cooperate and execute such other authorizations and releases for the above purposes as deemed necessary by Kansas City Urology Care, PA upon the practice's request. Kansas City Urology Care, PA may utilize information in my medical record that is necessary for research for quality improvement purposes.

Initials

NOTICE OF PRIVACY PRACTICES

As required by the Privacy Regulations set forth in the Health Insurance Portability & Accountability Act of 1996 (HIPAA), Kansas City Urology Care, PA has made available its Notice of Privacy Practice (Notice) to me, which describes how a patient's health information is used and shared. I acknowledge Kansas City Urology Care, PA has offered to provide me with access to its Notice in paper copy or at <https://www.kcuc.com/wp-content/uploads/2020/01/KCUC-Notice-of-Privacy-Practices-September-2013-Revision.pdf>, in whichever format that I prefer. I understand that Kansas City Urology Care, PA has the right to change this Notice at any time, and if the Notice changes, a current copy may be obtained by contacting Kansas City Urology Care, PA or by visiting the Kansas City Urology Care, PA website.

USE OF CONTACT INFORMATION: TELEPHONE CONSUMER PROTECTION ACT (TCPA)

By initialing and signing below, I acknowledge I have reviewed Kansas City Urology Care, PA's Notice of Privacy Practices (Notice) where it discusses how the practice may use my contact information. I agree that the practice, along with its affiliates and vendors, may call or text me as set forth in the Notice, including, but not limited to, using an automated telephone dialing system and/or an artificial voice. I further understand that I can opt out at any time by notifying the practice and/or the affiliate/vendor.

Initials

FINANCIAL POLICY & PAYMENT GUARANTEE

I have read and fully understand the financial policy set forth by Kansas City Urology Care, PA, at <https://www.kcuc.com/resources/patient-financial-policy/>, and I agree to the terms of this financial policy. I agree that the terms of the financial policy may be amended by the practice at any time without prior notification to me, the patient.

Initials

I understand that, in consideration of the services rendered to me, I am subject to all attorney fees, collection charges, and any other changes incurred if my portion of the bill is not paid when due.

Initials

DME WARRANTY COVERAGE

I understand Kansas City Urology Care, PA honors all warranties of manufacturers of the equipment the practice provides.

Initials

MEDICARE BENEFITS CONSENT

If I am covered by Medicare, I certify that the information given in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my, as the patient's, behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit claim to Medicare for payment to the patient.

Initials

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Authorization to Disclose Protected Health Information (PHI)

Please Print

Today's Date: _____

Patient Name: _____ Date of Birth: _____

Address: _____

Preferred Phone Number for Contact: _____

Describe the information you approve disclosure of:

- All aspects of my healthcare as allowed to me under applicable law
- Other: _____

To whom you approve disclosure (spouse, family, friend, etc.) * Indicates Required Field

Name*: _____ Relationship*: _____

Phone* #: _____ Address: _____

City: _____ State: _____ Zip Code: _____

Okay to leave a message*: _____

Name*: _____ Relationship*: _____

Phone* #: _____ Address: _____

City: _____ State: _____ Zip Code: _____

Okay to leave a message*: _____

Name*: _____ Relationship*: _____

Phone* #: _____ Address: _____

City: _____ State: _____ Zip Code: _____

Okay to leave a message*: _____

- I understand by completing this consent, you are authorizing KCUC physicians and staff to leave a message on an answering machine, voicemail or with a specified individual, which may include sensitive and/or PHI. You may specify what information is left and with whom by noting the information above.
- I understand that I still have a right to access my PHI as allowed under applicable law.
- I understand that I may revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written authorization to KCUC. I understand that my revocation will not apply to information already released in response to this authorization.

Signature of Patient or Legal Representative: _____

Printed Name of Legal Representative: _____ Relationship to Patient _____

Address and Phone Number of Legal Representative:



Patient History Form for Use with EMR

This is a confidential record and will be kept in your electronic patient chart

Information contained here will not be released to anyone without your authorization to do so.

TODAY'S DATE ____ / ____ / ____

DATE OF BIRTH ____ / ____ / ____

LAST NAME _____ FIRST NAME _____ M.I. ____

Reason for seeing the physician on the first visit: _____

Have you been exposed to or currently have TB (tuberculosis)? Y N

Have you received the Pneumonia Vaccine in the last 9 years? Y N Date _____

ALLERGIES/REACTIONS TO ANY MEDICATION OR FOOD:

LIST CURRENT MEDICATIONS (include over the counter items such as aspirin)

<u>MEDICATION/DOSAGE</u>	<u>MEDICATION/DOSAGE</u>
1. _____	7. _____
2. _____	8. _____
3. _____	9. _____
4. _____	10. _____
5. _____	11. _____
6. _____	12. _____

OVER-THE-COUNTER SUPPLEMENT MEDICATIONS (if nothing marked then NONE APPLY)

Echinacea	Metabolife	Garlic	Ginkgo	Ginseng
Kava	St. Johns Wort	Valerian	Fish Oil	Vitamin E
Other _____	Other _____			

Are you required to take antibiotics with dental work? N Y

LAST NAME _____ FIRST NAME _____ DOB _____

PAST SURGICAL HISTORY – Check previous surgeries & provide date *(if nothing marked then NONE APPLY)*

<input type="checkbox"/> Bladder augmentation _____	<input type="checkbox"/> Adrenalectomy _____
<input type="checkbox"/> Bladder suspension _____	<input type="checkbox"/> Appendectomy _____
<input type="checkbox"/> Cystectomy _____	<input type="checkbox"/> Back surgery _____
<input type="checkbox"/> Cystoscopy _____	<input type="checkbox"/> Breast biopsy _____
<input type="checkbox"/> Green light PVP _____	<input type="checkbox"/> CABG _____
<input type="checkbox"/> Hydrocele repair _____	<input type="checkbox"/> Cesarean section _____
<input type="checkbox"/> Kidney Stone Removal _____	<input type="checkbox"/> Cholecystectomy _____
<input type="checkbox"/> Laparoscopy _____	<input type="checkbox"/> Colon surgery _____
List type of Laparoscopy _____	<input type="checkbox"/> Colonoscopy _____
<input type="checkbox"/> Lithotripsy _____	<input type="checkbox"/> Coronary Stent _____
<input type="checkbox"/> Nephrectomy _____	<input type="checkbox"/> Gastric bypass _____
<input type="checkbox"/> Pacemaker _____	<input type="checkbox"/> Heart Valve Replacement _____
<input type="checkbox"/> Percutaneous nephrolithotomy _____	<input type="checkbox"/> Hernia repair _____
<input type="checkbox"/> Pubovaginal sling _____	<input type="checkbox"/> Hip replacement _____
<input type="checkbox"/> Tubal ligation _____	<input type="checkbox"/> Hysterectomy _____
<input type="checkbox"/> Ureteroscopy-stent _____	<input type="checkbox"/> Knee replacement _____
<input type="checkbox"/> Vasectomy _____	<input type="checkbox"/> Mastectomy _____
<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____

PAST MEDICAL HISTORY – Check any previous past medical problems *(if nothing marked then NONE APPLY)*

<input type="checkbox"/> Anemia	<input type="checkbox"/> Diabetes 1 OR 2 (circle one)	<input type="checkbox"/> Migraine headaches
<input type="checkbox"/> Angina (Chest Pain)	<input type="checkbox"/> Diverticular disease	<input type="checkbox"/> Multiple Sclerosis
<input type="checkbox"/> Arthritis	<input type="checkbox"/> GERD (Gastric Reflux)	<input type="checkbox"/> MI (Heart Attack)
<input type="checkbox"/> Asthma	<input type="checkbox"/> Gout	<input type="checkbox"/> Osteoarthritis
<input type="checkbox"/> BPH	<input type="checkbox"/> Hepatitis C	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Cancer _____	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Peptic Ulcer Disease
List type of cancer _____	<input type="checkbox"/> Hyperlipidemia	<input type="checkbox"/> Peripheral Vascular Disease
<input type="checkbox"/> CVA (Stroke)	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Renal Disease
<input type="checkbox"/> Chronic UTIs	<input type="checkbox"/> Hypothyroid	<input type="checkbox"/> Dialysis
<input type="checkbox"/> Congestive heart failure	<input type="checkbox"/> Inflammatory bowel disease	(<input type="checkbox"/> Hemo <input type="checkbox"/> Peritoneal)
<input type="checkbox"/> COPD	<input type="checkbox"/> Liver disease	<input type="checkbox"/> Rheumatoid Arthritis
<input type="checkbox"/> Coronary artery disease	<input type="checkbox"/> Lupus	<input type="checkbox"/> Seizure Disorder
<input type="checkbox"/> Depression		<input type="checkbox"/> Urolithiasis (Kidney Stones)
Other _____	Other _____	

LAST NAME _____ FIRST NAME _____ DOB _____

FAMILY HISTORY *Indicate what family member has the condition (FATH, MOTH, SIS, BRO, DAU, SON)*

Anesthesia Problems _____ Fallopian Tube Cancer _____ Kidney Stones _____ Polycystic Kidneys _____
Bladder Cancer _____ Gastric Cancer _____ Lung Problems _____ Prostate Cancer _____
Bleeding Disorders _____ Heart Disease _____ Melanoma _____ Strokes _____
Breast Cancer _____ High Blood Pressure _____ Metastatic Prostate Ca _____ Testicular Cancer _____
Colon Cancer _____ Kidney Cancer _____ Ovarian Cancer _____ Unknown History _____
Diabetes _____ Kidney Disease _____ Pancreatic Cancer _____ Uterine Cancer _____
Other Cancer (specify) _____

SOCIAL HISTORY: Please Circle Answers

Marital Status: Married Single Divorced Widowed Legally Separated Annulled Life Partner Unknown

Smoking Status: (please circle and answer as appropriate)

Current Every Day Smoker? When did you start smoking? _____ Packs smoked per day? _____

Current Some Day Smoker? When did you start smoking? _____ Packs smoked per day? _____

Former Smoker? When did you quit? _____ Packs smoked per day? _____ How long did you smoke? _____

Never Smoked Smoker, Current Status Unknown Unknown if ever smoked

Do you use Smokeless Tobacco? (please circle) Yes No

How many caffeinated drinks do you have each day? (please circle) 0 1 2 3 4+

Do you drink alcohol? (please circle) Yes _____ Not Anymore Never Drank

Type of alcohol consumed. (please circle) Beer Liquor Wine

Drinking habits? (please circle) Social Light Moderate Excessive

Do you use recreational drugs? (please circle) Yes No

Have you had a blood transfusion (please circle) Yes No

Race: (please circle) Unknown American Indian/Alaska Native Black/African American Eskimo

Native Hawaiian/other Pacific Islander White Asian Declined to Specify Hispanic/Latino

Language: (please circle) English Arabic Chinese Declined French German Italian Japanese

Portuguese Russian Spanish Vietnamese Other _____

Ethnicity: (please circle) Hispanic/Latino Not Hispanic/Latino Declined Unknown

Current/Former Occupation? _____

LAST NAME _____

FIRST NAME _____

DOB _____

REVIEW OF SYSTEMS – Please circle any symptoms you are currently experiencing.

Constitutional:	Fever	Chills	Weight Loss	
Eyes:	Blurry Vision	Cataracts	Glaucoma	
Ears, Nose, Mouth, Throat:	Hearing Loss	Nasal Stuffiness	Sore Throat	
Cardiovascular:	Chest Pains	Swollen Ankles	Irregular Heartbeat	
Respiratory:	Shortness Of Breath	Wheezing	Chronic Cough	Known TB Exposure
Gastrointestinal:	Abdominal Pain	Nausea/Vomiting	Change In Bowels	
Musculoskeletal:	Chronic Back Pain	Chronic Neck Pain	Sore Muscles	
Integumentary/Skin:	Rash	Persistent Itching	Skin Cancer History	
Neurological:	Numbness	Tingling	Dizziness	
Hematologic/Lymphatic:	Swollen Glands	Abnormal Bleeding	Transfusion History	
Psychiatric:	Anxiety	Depression		

Recent Colonoscopy: Date Of Procedure:

Recent Pneumonia Vaccine: Date Of Injection:

APPROXIMATE HEIGHT: _____

WEIGHT: _____

Physician Signature: _____ Date: _____