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

PCP Radio Social Media TV Billboard Other___________ Date: ______________________

PATIENT INFORMATION

Patient Name: ____ DOB: _________________Age: ________________

Address: ____City/State: _____________________________ Zip: _______________

Male or Female (circle one) Social Security #: ______________________ Marital Status S__M__LP__D__W__ No. of Children: ________

Race (circle one): White Black/African American Asian American Indian Multiracial Other Decline to Specify

Ethnicity (circle one): Hispanic Not Hispanic Other Decline to Specify Preferred Language: _______________________

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.

MEDICAL RECORDS RELEASE AUTHORIZATION

I authorize 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. The Practice may utilize information in my medical record that is necessary for research for quality improvement purposes.

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 the Practice has offered to provide me with access to its Notice in paper copy or by email, in whichever manner of delivery that I prefer. The Notice is also available www.kcuc.com/wp-content/uploads/2020/11/KCUC-Notice-of-Privacy-Practices-November-2020.pdf. 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) ________Initials

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. By signing below, 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. **I wish to opt out and have initialed above.**

FINANCIAL POLICY & PAYMENT GUARANTEE

I have read and fully understand the financial policy set forth by Kansas City Urology Care, PA, at 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. 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.

DME WARRANTY COVERAGE

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

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.

CHECKEDUP

I understand that my physician may utilize an interactive patient engagement platform called CheckedUp. This platform allows my physician to send me emails with patient education and other information that may be relevant to my care. **NOTE THIS EMAIL WILL NOT BE ENCRYPTED AND MAY BE AT RISK FOR INADVERTENT DISCLOSURE. BY PROVIDING YOUR EMAIL ADDRESS, YOU ACCEPT THIS RISK.**

Patient/Legal Representative Signature:_______________________________ Date:__________________________

Print Name:_____________________________________ Relationship to Patient:_______________________