Thank you for entrusting Kansas City Urology Care, PA d/b/a KCUC Urology & Oncology (the "Practice") with your urology and oncology care. Our physicians and office staff are eager to serve you.

In order to provide you with the best service 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 current 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 or radiation oncologist (specialists), 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 (updated 2023.01)

Thank you for choosing Kansas City Urology Care, PA as your urology and radiation oncology healthcare 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. Carefully review the following information. Please ask if you have any questions about our fees, our policies, or your responsibilities.

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. Non-covered services are the patient's responsibility. All copays and deductibles are the patient's responsibility. Copays 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 unless we are required to by law. Any remaining balance will become the patient's responsibility, including any non-covered amounts. If you have a question as to whether we accept your insurance plan, please contact our billing department at (913-341-7985) prior to your appointment.

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 or contact your insurance company for clarification.

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 for the visit.

Copays

Your insurance company requires us to collect copayments at the time of service. Waiver of copayments may constitute fraud under state and federal law. Please help us in upholding the law by paying your copayment 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 you have questions, we 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 copayments, coinsurance, deductibles, or other patient financial responsibility unless such action would be 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 Kansas City Urology Care, PA 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 Kansas City Urology Care, PA, 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

Kansas City Urology Care, PA may charge a $50 "no-show" fee for an office visit or $100 "no-show" fee for an in-office procedure 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

Kansas City Urology Care, PA 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 Kansas City Urology Care, PA. 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) a reasonable cost-based fee pursuant to 45 CFR 164.524 may be charged to provide copies of your medical records. There are several ways that you can request access to your medical records. You may request them directly from Kansas City Urology Care, PA. We also utilize an outside vendor called MediCopy to provide access to medical records and you can make a request directly to MediCopy through its website at https://medicopy.net/.

Card-on-File

Effective no sooner than February 20, 2023, Kansas City Urology Care, PA will begin requiring that patients keep an active credit/debit card on file which may be used to pay any balance that becomes due after your insurance processes our claim(s). If your insurance policy requires that you pay a copay or that you have an annual deductible/out-of-pocket amount, then you are required to add a card-on-file. This applies to Medicare without a Medigap secondary policy, Medicare Advantage and commercial/private insurance patients. Active Medicaid, Tricare and Workers Compensation patients are exempt. A copy of the Card-on-File policy is available upon request or can be located at www.kcuc.com.

Kansas City Urology Care, PA 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.

Kansas City Urology Care, PA 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 urology and radiation oncology 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 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.

AUTHORIZATION TO RELEASE INFORMATION

Kansas City Urology Care, PA uses the Epic EMR through Saint Luke's Health System (SLHS). I consent to the sharing of my health information within the SLHS for the purposes of treatment, payment, and healthcare operations. I understand that SLHS participates in various electronic health information exchanges designed to ensure my health information is available to all persons and entities providing me with care, payment for that care, or for other purposes permitted by law. This includes health information exchanges through Epic's Care Everywhere, and any other health information exchanges that SLHS participates in (collectively, the "Exchanges", full listing available at saintlukeskc.org/HIE). I understand that SLHS may disclose my health information to the Exchanges, and access my health information in the Exchanges, as outlined in this Consent. As the patient, I may choose to opt-out of providing this access by sending a request to medicalrecords@saintlukeskc.org using the subject line "HIE Opt-Out." Please include Patient Full Name, Date of Birth, and Phone Number so we can verify the request. To revoke this, opt-out request, send a request to medicalrecords@saintlukeskc.org using the subject line "Revoke HIE Opt-Out". Please include Patient Full Name, Date of Birth, and Phone Number so we can verify the request.

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 at 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 initialing and 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 understand that I can opt out at any time by notifying the Practice and/or the affiliate/vendor.

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 it is 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.

Patient/Legal Representative Signature:_____Date:_____

Print Name:_____Relationship to Patient:_____

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*: _____

- I understand by completing this authorization, 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 information 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:

_____

KCUC

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.

TODAY'S DATE _____ / _____ / _____ **DATE OF BIRTH** _____ / _____ / _____

LAST NAME _____ **FIRST NAME** _____ **M.I.** ___

Reason for seeing the physician on the first visit: _____

ALLERGIES/REACTIONS TO ANY MEDICATION OR FOOD:

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

MEDICATION/DOSAGE	MEDICATION/DOSAGE
1. _____	6. _____
2. _____	7. _____
3. _____	8. _____
4. _____	9. _____
5. _____	10. _____

OVER-THE-COUNTER SUPPLEMENT MEDICATIONS

_____ _____ _____ _____ _____

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

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

__Bladder augmentation_____
__Bladder suspension_____
__Cystectomy_____
__Cystoscopy_____
__Green light PVP_____
__Hydrocele repair_____
__Kidney Stone Removal_____
__Laparoscopy_____
List type of Laparoscopy
__Lithotripsy_____
__Nephrectomy_____
__Pacemaker_____
__Percutaneous nephrolithotomy_____
__Pubovaginal sling_____
__Tubal ligation_____
__Ureteroscopy-stent_____
__Vasectomy_____
__Other_____

__Adrenalectomy_____
__Appendectomy_____
__Back surgery_____
__Breast biopsy_____
__CABG_____
__Cesarean section_____
__Cholecystectomy_____
__Colon surgery_____
__ Colonoscopy _____
__Coronary Stent_____
__Gastric bypass_____
__Heart Valve Replacement_____
__Hernia repair_____
__Hip replacement_____
__Hysterectomy_____
__Knee replacement_____
__Mastectomy_____
__Other_____

Last Name _____ First Name _____ DOB _____

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

___ Anemia
___ Angina (Chest Pain)
___ Arthritis
___ Asthma
___ BPH
___ Cancer_____
List type of cancer
___ CVA (Stroke)
___ Chronic UTIs
___ Congestive heart failure
___ COPD
___ Coronary artery disease
___ Depression
___ Diabetes 1 OR 2 (circle one)
___ Diverticular disease
___ GERD (Gastric Reflux)
___ Gout
___ Hepatitis C
___ High Cholesterol
___ Hyperlipidemia
___ High Blood Pressure
___ Hypothyroid
___ Inflammatory bowel disease
___ Liver disease
___ Lupus
___ Migraine headaches
___ Multiple Sclerosis
___MI (Heart Attack)
___ Osteoarthritis
___ Osteoporosis
___Peptic Ulcer Disease
___Peripheral Vascular Disease
___ Renal Disease
___ Dialysis
(___Hemo ___Peritoneal)
___ Rheumatoid Arthritis
___ Seizure Disorder
___ Urolithiasis (Kidney Stones)
Other_____ Other_____

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

Anesthesia Problems _____ Colon Cancer _____ Kidney Stones _____ Pancreatic Cancer _____
Bladder Cancer _____ Gastric Cancer _____ Melanoma _____ Prostate Cancer _____
Bleeding Disorders _____ Kidney Cancer _____ Metastatic Prostate Ca _____ Testicular Cancer _____
Breast Cancer _____ Kidney Disease_____ Ovarian Cancer _____ Uterine Cancer _____
Other Cancer (specify) _____

SOCIAL HISTORY: Please Circle Answers

Smoking Status: (please circle) Current Smoker Previous Smoker
Began in year _____ Quit in year_____ Never 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

Drinking habits? (please circle) Social Light Moderate Excessive

Do you use recreational drugs? (please circle) Yes No If yes, what type? _____

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

Sexually Active? (please circle) Yes No Not Currently **Partners?** (please circle) Female Male Both

Approximate Height: _____ **Weight:** _____

Current/Former Occupation? _____