Last Name	Type of Insurance (circle) Medicare HMO/PPO/POS Other	
First Name, Middle initial	Person Responsible for bill: Self Parent Other	
Street Address		Date of Birth
City, State	Referring Doctor	Family Doctor
Zip Code	Patient Occupation	
Social Security # (Parent or Guardian)	Name & Address of Employer	
Home Telephone ( ) - Leave detailed message Yes____ No_____	Pharmacy, Location & Phone #	
Cell Telephone ( ) - Leave detailed message Yes ___ No _____	Emergency Contact	
Work Telephone ( ) -	( ) -	
E-Mail	Drivers License #	
Gender (Circle One) Male Female Marital Status (Circle one) S M D W	Spouse's Name .Number of Children	

Primary Insurance Co.	Secondary Insurance Co.	Tertiary Insurance Co.
Name of Primary Insured	Primary Insured Date of Birth	E-mail Address

Is Medicare your Secondary Insurance? ☐ No ☐ Yes - if yes check the applicable reason below

□ Working Aged Beneficiary or Spouse w/Employer Plan □ Workers' Compensation
□ No Fault Insurance Including Auto as Primary □ Veteran's Administration
□ Public Health Service(PHS) or other Federal Group □ Other Liability Insurance Primary
□ Disabled Beneficiary under Age 65 with Large Group Health Plan (LGHP)

Do you have a living will? ☐Yes ☐No Do you want information regarding a living will? ☐Yes ☐No

- I hereby extend authorization for myself or the above named patient to be seen, examined and treated by the Urology Group of Princeton physicians and staff as indicated by the standard of Urologic practice.
- I hereby request that payment of authorized (Medicare/Private Insurance) benefits be made on my behalf to the Urology Group of Princeton for any services furnished to me by that physician or supplier. I also authorize the holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits for a related service.
- I hereby authorize the release of medical information to my referring physician
- I understand that any charges incurred by myself or the above named patient are my responsibility.
- I understand that a no show charge of $25 or $50 might be incurred if I do not cancel my appointment 1 business day before my appointment
- **Patient/Guardian Signature** _____ **Date** _____

Patient Medical Information

Explain briefly what brought you to the office to see the doctor today:

What is your approx Height? _____Ft. _____ Inches Approx Weight? _____Lbs.

Genito-Urinary History

	Not at All	Less than 1 time in 5	Less than half the time	Abut half the time	More than half the time	Almost always
Incomplete Emptying – Over the past few months how often have you had a sensation of not emptying your bladder completely after you finished urinating?	0	1	2	3	4	5
Intermittency – Over the past month how often have you found you stopped and started again several times during urinating?	0	1	2	3	4	5
Urgency – Over the past month, how often have you found it difficult to postpone urination?	0	1	2	3	4	5
Frequency – Over the past month, how often have you had to urinate again less than two hours after you finished urinating?	0	1	2	3	4	5
Weak Stream – Over the past month, how often have you had a weak urinary stream?	0	1	2	3	4	5
Straining – Over the past month, how often have you had to push or strain to begin urination?	0	1	2	3	4	5
Nocturia – How many times do you typically get up at night to urinate, from the time you go to bed until the time you get up in the morning?	0 times	1 time	2 times	3 times	4 times	5 times

Total Score _____

If you were to spend the rest of your life with your voiding condition just the way it is now, how would you feel about that? (Circle your answer)

Delighted Pleased Mostly Satisfied Mixed Most Dissatisfied Unhappy Terrible

Do you have leakage of urine? ○Yes ○No

How many pads do you use each day (if applicable)? ___ Pads per day

Do you have:

A history of bladder, kidney or prostate infections? ○Yes ○No

A history of blood in the urine? ○Yes ○No

A history of kidney stones? ○Yes ○No

Difficulty or dissatisfaction with sexual function? ○Yes ○No

A history of HIV/Venereal Disease? ○Yes ○No

Please review the following review of systems and check off any symptoms that have effected your current and prior health. If you have not experienced symptoms in a particular system check "negative".

Constitutional: ❑ Weight Loss/Gain ❑ Fatigue ❑ Fever/Chills, Sweats ❑ Other _____ ❑ **Negative**	**Psychiatric:** ❑ Depression ❑ Anxiety ❑ Other _____ ❑ **Negative**
Eyes: ❑ Blurry Vision/glasses ❑ Cataracts ❑ Glaucoma ❑ Other _____ ❑ **Negative**	**Gastrointestinal:** ❑ Nausea/Vomiting ❑ Diarrhea/Constipation ❑ Blood in Stool ❑ Other _____ ❑ **Negative**
Ears/Nose/Mouth/Throat: ❑ Ringing in Ears/Hearing Loss ❑ Nasal Discharge/Bleeding ❑ Sore Throat ❑ Other _____ ❑ **Negative**	Gynecologic: (Woman only) ❑ Menopause/ Abnormal Menses ❑ Breast Lump ❑ Vaginal Discharge/Problems ❑ Other _____ ❑ **Negative**
Cardiovascular: ❑ Irregular Heartbeat ❑ Chest Pain (Angina)/Heart Attack ❑ Heart Murmur/Valve Problem ❑ Elevated Cholesterol ❑ Hypertension/High Blood Pressure ❑ Other _____ ❑ **Negative**	**Respiratory:** ❑ Cough ❑ Shortness of Breath ❑ Wheezing ❑ Other _____ ❑ **Negative**
Musculoskeletal: ❑ Joint Pain/Arthritis ❑ Low Back Pain ❑ Other _____ ❑ **Negative**	**Endocrine:** ❑ Diabetes ❑ Thyroid Disease ❑ Adrenal Disease ❑ Erectile Dysfunction/Loss of Libido ❑ Other _____ ❑ **Negative**
Skin: ❑ New Skin Lesion ❑ Rash/Dry Skin ❑ Skin Cancer ❑ Other _____ ❑ **Negative**	**Hematological:** ❑ Easy Bruising/Bleeding ❑ Swollen Lymph Nodes ❑ Other _____ ❑ **Negative**
Neurologic: ❑ Numbness of Arms/Legs/Face ❑ Weakness of Arms/Legs/Face ❑ Memory Loss ❑ Other _____ ❑ **Negative**	Reviewed By: _____ (Physician's signature) Date reviewed: _____ **Re-review** ____ ____ ____ ____ ____ ____ ____ ____ ____ ____ ____ ____ ____ ____ ____ ____ ____ ____

How many pregnancies? _____ How Many children? _____

Please list any gynecological problems for which you have been treated.

Medication History

Do you have a heart murmur, heart valve or joint replacement that requires antibiotics for dental work?
□ Yes □ No

Are you currently taking any medications or vitamins? □ Yes (please specify) □No

Specify current medication	Dosage	How often taken
Aspirin, Antinflammatories, Coumadin, Vitamin E, Herbs		

DO YOU HAVE ANY ALLERGIES YES__NO_____

History of Medical Illness

List all condition for which you have received evaluation or treatment such as asthma, heart disease, high blood pressure, elevated cholesterol, ulcers, diabetes, strokes, etc.

Date	Specify type of Medical Illness

History of Surgery

List all surgeries which you have had including appendectomy, hysterectomy, tonsillectomy, hernia repair, etc.

Date	Specify type of Surgery

Social/Family History

Do you currently smoke? □ No □ Yes ___packs per day for the last ____ years
Have you been a smoker in the past? □ No □ Yes ____ years Quit? ____# years ago
Do you drink wine, beer or alcoholic beverages? □ daily □socially □ rarely □ never
How many cups of caffeinated beverages (coffee, tea, cola) do you consume in a day? ___#of cups
Do you have a family history of Cancer? □ Yes □ No
Do you exercise regularly? □ Yes □ No
Circle if any family history of Genito Urinary Cancer – Prostate, Kidney, Bladder, Uterine, Ovarian, Breast

Reviewed By Physician: _____

PATIENT COPY

Urology Group of Princeton
Forrestal Village
134 Stanhope Street
Princeton, New Jersey 08540
609) 924-6487

Notice of Practice Privacy Practices
(As required by the Health Insurance Portability and Accountability Act of 1996 –HIPAA)

This notice describes how health information about you, a patient in our practice, may be used and disclosed as well as how you can get access to your Individually Identifiable Health Information (IIHI).

The Urology Group of Princeton is committed to maintaining the privacy of your Individually Identifiable Health Information. While conducting the business of providing your healthcare, we create records regarding you and the treatment and services we provide to you. We are required by law to maintain this notice of our legal duties and the privacy practices that we maintain in our practice. By federal and state law, we must follow the terms of the privacy practices that we have in effect at the time.

HIPPA laws can be very complicated and confusing. We will do our best to explain the following important information contained in the law:

- How we may use and disclose your IIHI
- Your privacy rights in your IIHI
- Our obligation concerning the use and disclosure of your IIHI

The terms of this notice apply to all records containing your IIHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all your records that our practice has created or maintained in the past, and for any of your records that we create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

A. The Urology Group of Princeton may use and disclose your individually identifiable health information (IIHI) in the following ways:

1. **Treatment.** Our practice may use your IIHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests) and we may use the results to help us reach a diagnosis. We may use your IIHI in order to write a prescription for you, or we may need to disclose you IIHI to a pharmacy when we order a prescription for you. Many of the employees of the Urology Group of Princeton, including but not limited to the physicians and nurses – may use or disclose your IIHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your IIHI to others

who may assist in your care, such as your spouse, children or parents. Finally, we may disclose your IIHI to another healthcare provider for purposes related to your treatment.

2. **Payment.** Our practice may use and disclose your IIHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits, and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your IIHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your IIHI to bill you directly for services and items. We may disclose your IIHI to other health care providers and entities to assist in their billing and collection efforts.

3. **HealthCare Operations.** Our practice may use and disclose your IIHI to operate our business. For example, we may use or disclose your information for our operations, to evaluate the quality of care you receive from us, or to conduct cost management and business planning activities for our practice. We may disclose your IIHI to other healthcare providers and entities to assist in their healthcare operations.

4. **Appointment Reminders.** Our office may use or disclose your IIHI to contact you to remind you of an appointment.

5. **Treatment Options.** Our practice may use or disclose your IIHI to inform you of potential treatment options or alternatives.

6. **Health Related Benefits and Services.** Our practice may use and disclose your IIHI to inform you of health-related benefits or services that may be of interest to you.

7. **Disclosures Required by Law.** Our practice will use and disclose your IIHI when we are required to do so by federal, state or local law.

8. **Release of Information to Family/Friends involved in your care**. Our practice may release your IIHI to a family member or a friend that is involved in your care, or who assists in taking care of you.

B. The following categories describe unique scenarios in which we may use or disclose your IIHI:

1. **Deceased Patients**. Our practice may release IIHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for the funeral directors to perform their jobs.

2. **Organ and Tissue Donation.** Our practice may release your IIHI to organizations that handle organ, eye or tissue procurement or transplantation, including donation banks, as necessary to facilitate organ or tissue donation or transplant if you are an organ donor.

3. **Research.** Our practice may use and disclose your IIHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your IIHI for research purposes except when an Institutional Review Board or Privacy Board has determined that the research consent adequately serves to protect your privacy.

4. **Serious Threats to Health Safety.** Our practice may use and disclose your IIHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

5. **Military.** Our practice may use or disclose your IIHI if you are a member of the U.S. or foreign military forces (including veterans) and documents are required by the appropriate government authorities.

6. **National Security.** Our practice may use and disclose your IIHI to federal officials for intelligence and national security activities authorized by law.

7. **Workers' Compensation.** Our practice may release your IIHI for workers' compensation and similar programs.

C. Your Rights regarding your IIHI

1. **Confidential Communication.** You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than at work. In order to request a certain type of confidential communication, you must make a written request to Sandra Wittmann (609) 924-6487, specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate reasonable requests. You do not need to give a reason for your request.

2. **Requesting Restrictions.** You have a right to request a restriction in our use or disclosure of your IIHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your IIHI to only certain individuals involved in your care or the payment of your care, such as family members or friends. WE ARE NOT REQUIRED TO AGREE WITH YOUR REQUEST; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use and disclosure of your IIHI, you must make your request in writing to our Administrator (609) 924-6487. Your request must describe, be clear and concise:

    1. the information which you wish restricted
    2. whether you are requesting to limit our practice's use, disclosure or both; and
    3. to whom you want the limits to apply.

3 **Inspection and copies.** You have the right to inspect and obtain copies of the IIHI that may be used to make decisions about you, including patient

medical records and billing records, but not psychotherapy notes. You must submit your request in writing to our Medical Records Coordinator in order to inspect and /or obtain a copy of your IIHI. Our practice will charge a $1.00 per page fee for the cost of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct the review.

4. **Amendment.** You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to our Administrator. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion (a) accurate and complete; (b) not part of the IIHI kept by our practice; (c) not part of the IIHI which you would be permitted to inspect or copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

5. **Accounting of Disclosures.** All of our patients have the right to request an "accounting of disclosures". An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your IIHI for non-treatment, non-payment or non-operational purposes. Use of your IIHI as part of the routine patient care in our practice is not required to be documented. For example, if the doctor shares information with the nurse; or the billing department uses your information to file an insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to our Administrator. All requests for "accounting disclosures" must state a time period, which may not be longer than 6 years from the date of the disclosure and may not include dates before April 14, 2003.

   The first list you request within a 12- month period is free of charge, but our practice will charge you got additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. **Right to a paper copy of this notice.** You are entitled to receive a paper copy of our notice of privacy policies, You may ask us for a copy of this notice at any time, to obtain a paper copy of this notice, contact our Medical Records Coordinator.

7. **Right to File a Complaint.** If you believe that your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact our Administrator. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

8. **Right to provide authorizations for other uses and disclosures.** Our practice will obtain a written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your IIHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your IIHI for the reason described in the authorization. Please note we are required to retain record of your care.

If you have any questions about this notice, please contact our office at (609) 924-6487.

Urology Group of Princeton
Forrestal Village
134 Stanhope Street
Princeton, New Jersey 08540

Receipt of Notice of Privacy Practices
Written Acknowledgement Form

I, _____, have received a copy of the Urology Group of
(print name)
Princeton's Notice of Privacy Practices.

_____ _____
Signature of Patient Date

PATIENT COPY

Urology Group of Princeton
Forrestal Village
134 Stanhope Street
Princeton, New Jersey 08540
609) 924-6487

Notice of Practice Privacy Practices
(As required by the Health Insurance Portability and Accountability Act of 1996 –HIPAA)

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HIPPA laws can be very complicated and confusing. We will do our best to explain the following important information contained in the law:

- How we may use and disclose your IIHI
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A. The Urology Group of Princeton may use and disclose your individually identifiable health information (IIHI) in the following ways:

1. **Treatment.** Our practice may use your IIHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests) and we may use the results to help us reach a diagnosis. We may use your IIHI in order to write a prescription for you, or we may need to disclose you IIHI to a pharmacy when we order a prescription for you. Many of the employees of the Urology Group of Princeton, including but not limited to the physicians and nurses – may use or disclose your IIHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your IIHI to others

who may assist in your care, such as your spouse, children or parents. Finally, we may disclose your IIHI to another healthcare provider for purposes related to your treatment.

2. **Payment.** Our practice may use and disclose your IIHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits, and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your IIHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your IIHI to bill you directly for services and items. We may disclose your IIHI to other health care providers and entities to assist in their billing and collection efforts.

3. **HealthCare Operations.** Our practice may use and disclose your IIHI to operate our business. For example, we may use or disclose your information for our operations, to evaluate the quality of care you receive from us, or to conduct cost management and business planning activities for our practice. We may disclose your IIHI to other healthcare providers and entities to assist in their healthcare operations.

4. **Appointment Reminders.** Our office may use or disclose your IIHI to contact you to remind you of an appointment.

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2. **Organ and Tissue Donation.** Our practice may release your IIHI to organizations that handle organ, eye or tissue procurement or transplantation, including donation banks, as necessary to facilitate organ or tissue donation or transplant if you are an organ donor.

3. **Research.** Our practice may use and disclose your IIHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your IIHI for research purposes except when an Institutional Review Board or Privacy Board has determined that the research consent adequately serves to protect your privacy.

4. **Serious Threats to Health Safety.** Our practice may use and disclose your IIHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

5. **Military.** Our practice may use or disclose your IIHI if you are a member of the U.S. or foreign military forces (including veterans) and documents are required by the appropriate government authorities.

6. **National Security.** Our practice may use and disclose your IIHI to federal officials for intelligence and national security activities authorized by law.

7. **Workers' Compensation.** Our practice may release your IIHI for workers' compensation and similar programs.

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2. **Requesting Restrictions.** You have a right to request a restriction in our use or disclosure of your IIHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your IIHI to only certain individuals involved in your care or the payment of your care, such as family members or friends. WE ARE NOT REQUIRED TO AGREE WITH YOUR REQUEST; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use and disclosure of your IIHI, you must make your request in writing to our Administrator (609) 924-6487. Your request must describe, be clear and concise:

    1. the information which you wish restricted
    2. whether you are requesting to limit our practice's use, disclosure or both; and
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medical records and billing records, but not psychotherapy notes. You must submit your request in writing to our Medical Records Coordinator in order to inspect and /or obtain a copy of your IIHI. Our practice will charge a $1.00 per page fee for the cost of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct the review.

4. **Amendment.** You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to our Administrator. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion (a) accurate and complete; (b) not part of the IIHI kept by our practice; (c) not part of the IIHI which you would be permitted to inspect or copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

5. **Accounting of Disclosures.** All of our patients have the right to request an "accounting of disclosures". An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your IIHI for non-treatment, non-payment or non-operational purposes. Use of your IIHI as part of the routine patient care in our practice is not required to be documented. For example, if the doctor shares information with the nurse; or the billing department uses your information to file an insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to our Administrator. All requests for "accounting disclosures" must state a time period, which may not be longer than 6 years from the date of the disclosure and may not include dates before April 14, 2003.

   The first list you request within a 12- month period is free of charge, but our practice will charge you got additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. **Right to a paper copy of this notice.** You are entitled to receive a paper copy of our notice of privacy policies, You may ask us for a copy of this notice at any time, to obtain a paper copy of this notice, contact our Medical Records Coordinator.

7. **Right to File a Complaint.** If you believe that your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact our Administrator. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

8. **Right to provide authorizations for other uses and disclosures.** Our practice will obtain a written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your IIHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your IIHI for the reason described in the authorization. Please note we are required to retain record of your care.

If you have any questions about this notice, please contact our office at (609) 924-6487.

Urology Group of Princeton
Forrestal Village
134 Stanhope Street
Princeton, New Jersey 08540

Receipt of Notice of Privacy Practices
Written Acknowledgement Form

I, _____, have received a copy of the Urology Group of
(print name)
Princeton's Notice of Privacy Practices.

_____ _____
Signature of Patient Date

UROLOGY GROUP of PRINCETON

134 STANHOPE STREET

PRINCETON, NJ 08540

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE

OF PROTECTED HEALTH INFORMATION

The Health Insurance Accountability and Portability Act of 1996, HIPAA, requires that we have your consent prior to our healthcare professional discussing your personal health with your family members or significant others that are not directly involved in your care.

Can our physicians discuss your healthcare with any of your family members? ____ Yes ____ No

Please circle those that apply

Spouse Mother Father Sister Brother Child Other

Provide Name, Relationship, and Telephone # of designated contact:

I hereby give my permission to the Urology Group of Princeton, allowing for the physicians or their representatives to release or discuss authorized medical information and/or billing issues, with the above family members or to leave a voicemail message at the designated phone number where appropriate.

Leave Voicemail (Home / Cell) Discuss Billing Issues with Family Member

__ Yes __ No __ Yes __ No

Please indicate a specific family member if desired _____

This authorization will be in effect until such time as you request its revision. Release of Patient Personal Health Information covered by this authorization will be disclosed only for the purpose of keeping your designated family members knowledgeable about your healthcare condition.

You do not have to sign this authorization in order to receive treatment from the Urology Group of Princeton. You have the right to revoke this authorization in writing to the extent that the practice has acted in reliance upon this authorization; your written revocation must be submitted to the Privacy Officer at 134 Stanhope Street, Princeton, NJ 08540.

PRINT NAME _____

SIGNED BY_____ DATE _____

Urology Group of Princeton

FINANCIAL POLICY

Regarding Insurance: In order to be seen by physicians at the Urology Group of Princeton and receive care through your insurance carrier, you must provide us with your insurance card. For Medicare patients, this includes both your Medicare card and your card for any other health insurance, (supplementary coverage) that you have. If you receive a new card, you must provide it to us. If your insurance has lapsed or is not in effect at the time of service, you will be required to pay the entire bill for services provided when the insurance has lapsed or is not in effect.

If we have a contract with your insurance plan:

- If you have an HMO insurance plan with which we have a contract, then before you come for your appointment with us, you must obtain a proper referral from your Primary Care Physician containing a diagnosis, and stating the number of office visits approved, and the date the referral expires. **You** are responsible to keep track of the number of visits allowed and the expiration date. If your referral expires or you use all allowed visits, and then you are seen by one of our providers, you will be responsible for the entire bill for that visit. If your card says that you have a copay, you must pay that copay before you will be seen for your appointment.
- If you have a PPO or POS insurance with which we have a contract, you do not need a referral to see us. POS insurance is your choice whether you choose to have a referral or pay on your deductible. If your card says that you have a copay, you must pay that copay before you will be seen for your appointment. We will bill your insurance the balance. If your insurance company tells us that you have not satisfied your deductible for the year, then we will bill you for the deductible amount that you are required to pay, and you must pay us.

If we DO NOT have a contract with your insurance plan:

- You will be required to pay in full for our services at the time of the visit. Please do not ask our front desk personnel to send you a bill after services have been performed, unless approved in advance by the office manager when the appointment is made.
- We will submit a bill to your insurance company unless you ask us not to do so, with the instruction for your insurance carrier to make payment to you (because you already have paid us). If you do not agree with your plan's payment, that is between you and your plan, because we do not have a contract with your plan.

If you are not sure whether we have a contract with your insurance plan, please discuss this with our staff.

Medicare Patients:

- You must give us your Medicare card and any card for your supplemental or other insurance (where applicable).
- You will be required to satisfy your annual $162.00 deductible and pay your 20% copayment. If you have given us your Medicare card and other supplemental insurance cards, we do not require that you pay us at the time of service, and we will submit the claim to Medicare and to any secondary or supplemental insurance that you have.
- Approximately thirty to sixty days after the appointment, we will bill you for the balance that you owe to us, which will be the amount allowed for the service by Medicare, minus the amount that Medicare has paid us, and also minus any amount that your supplemental insurance has paid us. You are required to pay this bill.

Medicaid Patients:

- We are not contracted with any type of Medicaid Plans. Therefore, if you have Medicare as your primary insurance and Medicaid as your secondary insurance you will be required to pay the 20% balance at the time of service. If you have a Medicare deductible you will be responsible for that balance.

Regarding Biopsy Charges: There will be an additional fee charged by an outside lab for the processing of any biopsies taken either in our office or our surgery center. The professional component of reading/interpreting the pathology tissue will also be billed separately either by one of our employed pathologist or an outside pathology lab.

About non-covered services: A service considered by your insurance carrier to be non-medically necessary [cosmetic or otherwise] will not be covered by your insurance policy. You will be required to pay in full for this service in advance. Payment will be expected at the time of service in this circumstance, unless arrangements are made with our office administrator.

Thank you for your understanding of our financial policy. Please let us know if you have any questions or concerns.

I have read the Financial Policy (above). I have asked any questions that I had about this Financial Policy. I understand and agree to this Financial Policy.

_____ _____

Signature of Patient or Responsible Party Print Name of Patient

_____ _____

Relationship/Authority of Responsible Party Date